**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41001

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| John E. Ott | November 26, 2003 | 8:45 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Northampton Manor Nursing Home | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 203-05-9923 | 1 [X] M 2 [ ] F | 85 Yrs. | | | Sept. 11, 1918 | Pennsylvania |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8878 Briarcliff Lane | 21701 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Museum Specialist | Museum |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Ott | Rosalia Ott |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Martha Ott, wife | 8878 Briarcliff Lane, Frederick, MD 21701 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | St. Nivholas Cemetery | 12/1/2003 | Shavertown, Pennsylvania |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Ryan M. Berger M00999 | Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Aspiration Pneumonia | Days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No | 24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No |
|---|---|

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

| 25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No | 26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |
|---|---|

| 27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D43091 | 11/27/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Saeed Zaidi MD 801 Toll House Ave Frederick MD

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC - 1 2003 | [signature] |

**State Registrar**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41002

OLTMAN, ELIZABETH S.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): ELIZABETH SHOCKLEY OLTMAN
2. Date of Death (Month, Day, Year): NOVEMBER 29 2003
3. Time of Death: 1:35P M
4a. Facility Name (If not institution, give street and number): Berlin Nursing and Rehabilitation Center
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester
5. Social Security Number: 216-16-7713
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/14/1924
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Berlin
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9844 N. Main St.
10f. Zip Code: 21811
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): John E. Shockley
18. Mother's Name (First, Middle, Maiden Surname): Elsie Mae Timmons
19a. Informant's Name/Relationship (Type, Print): Patricia Oltman
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12908 Center Dr. Ocean City, MD 21842
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Cemetery
Date: 12/4/03
20c. Location - City or Town, State: Berlin, MD
21. Signature of Funeral Service Licensee: W. Fitch Burbage
22. Name and Address of Facility: The Burbage Funeral Home 108 William St. Berlin, MD 21811

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Amyotrophic Lateral Sclerosis, End Stage — 10+ yrs
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Essential Hypertension
Diverticulosis

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Gregorio M. Belloso, M.D.
29c. License number: D29505
29d. Date signed (Month, Day, Year): 12-01-2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

DH 5

**State Registrar**

31. Date filed (Month, Day, Year): DEC 02 2003
32. Registrar's Signature: Donna L. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41003

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| John | Wilson | Parsons | DECEMBER 03 2003 | 2345 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| MEMORIAL HOSPITAL | CUMBERLAND | ALLEGANY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 483-05-2169 | 1☒M 2☐F | 83 Yrs. | | | 01/25/1920 | Iowa |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Allegany | Cumberland | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15 Cumberland Street | 21502 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: WWII | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 5 | Biologist | Marine |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Carl Parsons | Adelia Hartman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sue Moessinger /daughter | 15817 Evitts Mt. Lane, Cumberland, MD 21502 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Cumberland Crematory | 12/04/2003 | Cumberland, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Robert C. Adkerson | Merritt-Adams Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. INTRACEREBRAL HEMORRHAGE | IMMEDIATE |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Steven R. Smith M.D. | D0018216 | 12/4/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN SMITH,M.D. 600 MEMORIAL AVENUE CUMBERLAND,MD 21502

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 04 2003 | Donna L Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2

NDS

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41004

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Martin J. Pietryak | 11/28/2003 | 1427 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Atlantic General Hospital | Berlin | Worcester |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 127-24-0898 | 1 XX 2 F | 71 Yrs. | | | 06/27/1932 | NY |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| N.J. | Bergen | Northvale | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 416 Longview Court | 07647 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 XX Widowed 4 Divorced | 1 XX Yes 2 No If Yes, Give Year or Dates: 1950 | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Regional Manager | Telephone Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Carlo Pietryak | Rose Mazzucchi |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Martin R. Pietryak (Son) | 3707 Diane Avenue Hampstead, MD 21074 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 Cremation 3 XX Removal from State 4 Donation 5 Other (Specify) | Rockland Cemetery | 12/2/03 | Sparkill, NY |

21. Signature of Funeral Service Licensee: Jacqueline Y. Doherty

22. Name and Address of Facility: The Burbage Funeral Home 108 William Street Berlin, MD 21811

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. AS CVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. FEW YEARS

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown | | |
|---|---|---|
| | 24a. Was an autopsy performed? 1 Yes 2 X No | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |

| 25. Was case referred to medical examiner? 1 X Yes 2 No | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Dorothy C. Holzworth, M.D. | D 06241 | 11-29-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dorothy C. Holzworth, M.D. 203 Snow St. Snow Hill, MD. 21863

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 02 2003 | Sharon D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Martin Pietryak DOB 6/27/1932 DOD 11/28/2003 1427 127-24-0898

C.H. 2041

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #5 per fh G827 1/8/04 Las

# Certificate of Death

Reg. No. 2003 41005

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| LOUIS BALDWIN PASSANO | 11 / 27 / 2003 | 12:40 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Heartfield's Assisted Living | Easton | Talbot |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| ~~213-10-3845~~ 213-01-3845 | 1 [X] M 2 [ ] F | 94 Yrs. | | | 7/31/1909 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Talbot | Easton | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 700 Port St. Apt. 1101 | 21601 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Vice President | Bank |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Louis Passano | Etha Barr |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| George Passano | PO Box 27 Oxford, MD 21654 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) / Date | 20c. Location - City or Town, State |
|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Cape Henlopen Crematory 12/1/03 | Frankford, DE |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| W. Kirk Burbage | The Burbage Funeral Home 108 William St. Berlin, MD 21811 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Aspiration Pneumonia | 2 weeks |
| | Due to (or as a consequence of): | |
| | b. Inanition | 6 months |
| | Due to (or as a consequence of): | |
| | c. End Stage Prostate Cancer | 3 years |
| | Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Assisted Living

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| R. Bailey DO. | 1442587 | 12/01/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Russell A. Schilling, DO 555 Cynwood Dr. Easton, MD 21601

DH 641

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 02 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41006

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Percell E. Poole

2. Date of Death: Month 11 Day 26 Year 03

3. Time of Death: 1217 M

4a. Facility Name (If not institution, give street and number): Peninsula Regional Medical Center

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 228-42-6659

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11-01-33

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Va.

10b. County: Accomack

10c. City, Town or Location: Wattsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7186 Flemings Rd.

10f. Zip Code: 23415

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Blk

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Store Manager

16b. Kind of Business/Industry: Fabric

17. Father's Name (First, Middle, Last): George H. Poole

18. Mother's Name (First, Middle, Maiden Surname): Flora Nottingham

19a. Informant's Name/Relationship (Type, Print): Sandra Stevens Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2319 Worcester Hwy. Pocomoke City, Md.

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Friendship Ch. Cem. Date: 11-29-03

20c. Location - City or Town, State: Wattsville, Va.

21. Signature of Funeral Service Licensee: Edgar K. Wharton

22. Name and Address of Facility: Wharton Funeral Home 22171 Wharton Rd. Accomac, Va. 23301

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE ORGAN FAILURE — 2 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. AORTIC AND MITRAL VALVE REPLACEMENT — 2 WKS

Due to (or as a consequence of):

c. RHEUMATIC HEART DISEASE — 50+ YEARS

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D53551

29d. Date signed (Month, Day, Year): 12-15-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James C Todd III MD 201 Pine Bluff Rd Salisbury MD 21801

**State Registrar**

31. Date filed (Month, Day, Year): DEC 01 2003

32. Registrar's Signature:

DHMH 17 Rev 1/2001

ET 3

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41007

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| BETTY LEE POTTS | NOV. 29 2003 | 1:41 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-24-2440 | 1☐M 2☒F | 74 Yrs. | | | 06/06/1929 | SALISBURY, MD. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | SOMERSET | PRINCESS ANNE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 33076 W. POST OFFICE ROAD | 21853 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | SELF EMPLOYED | POULTRY FARM |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CHARLES DAVIS | GLADYS QUILLEN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ARLAIN POTTS - SPOUSE | 33076 W. POST OFFICE RD, PRINCESS ANNE, MD. 21853 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | WICOMICO MEM. PARK | 12/03/2003 | SALISBURY, MARYLAND |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MYOCARDIAL INFARCTION.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D38353 | NOV. 30, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RENE DESMARAIS MD 560 Riverside Dr. B101 Salisbury Md

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 02 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BETTY LEE POTTS 213-24-2440

10 DQ

03-8002
B.K.S
CARLOS J. QUINONES

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41008

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| CARLOS J. QUINONES | DEC. 12, 2003 | 0636 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 18414 BEALLSVILLE ROAD | POOLSVILLE | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-04-7056 | 1 X M 2 ☐ F | 22 Yrs. | | | DEC 16 1980 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | MONTGOMERY | POOLESVILLE | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 17608 SOPER STREET | 20837 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 X Yes 2 ☐ No Specify: PUERTO RICAN | Specify: HISPANIC |

| 15. Decedent's Education (Specify only highest grade completed) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|
| Elementary/Secondary (0-12): 12 College (1-4or 5+): | PRODUCTION MANAGER | NEUTRON PRODUCTS |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| EDUARDO QUINONES | LUZ M. ROBLES |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| EDUARDO QUINONES / FATHER | 17608 SOPER ST., POOLESVILLE, MD 20837 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | MONOCACY CEMETERY | 12/16/03 | BEALLSVILLE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| W.O. Dan | HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple injuries

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 ☐ No | 1 X Yes 2 ☐ No |

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 XX Other (Specify) AT SCENE

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☐ Natural 2 X Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 12-12-03 | 6:33 A M | 1 ☐ Yes 2 X No | Driver of motor vehicle that collided with another motor vehicle |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Road

28f. Location (Street and Number or Rural Route Number, City or Town, State): 18414 Beallsville Rd Poolsville MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| LING LI. M.D | O.C.M.E | DEC. 13, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type. Print): LING LI. M.D 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 18 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41009

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Donna Lee Rubino | 12 - 02 - 03 | 13:29 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SACRED HEART HOSPITAL | CUMBERLAND | ALLEGANY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-36-8923 | 1☐M 2☒F | 65 Yrs. | | | 31-May-1938 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Allegany | Frostburg | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 99 Washington Street | 21532- | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | secretery/bookkeeper | trash collection |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Ralph Beal | Leannah Kroll |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sharon Festerman daughter | 911 Finzel Road Frostburg Maryland 21532- |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Frostburg Memorial Park | 05-Dec-2003 | Frostburg Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| John R. Durst | Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pulmonary Embolism | 30 min. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

DEC 4,2003

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Stent Thrombosis

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No Released | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Wonsock Shin MD | D0055325 | Dec 03, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WONSOCK SHIN MD 48 Tarn Terrace Frostburg, MD21532.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 04 2003 | G Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41010

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Donna Lee Richardson | 12 | 04 | 03 | 10:28 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sacred Heart Hospital | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-40-2814 | 1☐ M 2☒ F | 61 Yrs. | | | August 31, 1942 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Allegany | Cumberland | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 901 Seton Drive Ext. | 21502 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No *Specify:* | *Specify:* White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Ellsworth Johnson Sr. | Twilia Elkins |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Kimberly Ann Sines-Daughter | 13101 Gramlich Road S.W., LaVale,Md. 21502 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Oak Hill Cemetery | December 07, 2003 | Lonaconing, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ James E Metz | Eichhorn-McKenzie Funeral Home P.A. 8 E. Main St.,Lonaconing,Md.21539 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ARRhythmiA | 30 m.d |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Asthmatic Bronchitis
Diabetes Mellitus
Schizoaffective Disorder

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Robert Welik | D31875 | DECEMBER 4 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Robert Welik 902 Seton Drive Cumberland, MD 21502

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 0 8 2003 | ▶ Donna G Sparks |

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Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41011

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| RUTH M. RICHARDSON | 12 | 01 | 2003 | 8:A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SARAH MARGARETS & MOLLIES PLACE, INC. | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-01-6011 | 1☐ M 2☒ F | 89 Yrs. | | | 10/20/1914 | VIRGINIA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | DORCHESTER | VIENNA | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 119 WATER STREET BOX 134 | 21869 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | BUS DRIVER | DORCHESTER COUNTY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| REV. WILLIAM C. MUMFORD | SADIE R. RITCHIE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| SUE R. LANKFORD - DAUGHTER | 228 GLEN AVENUE, SALISBURY, MARYLAND 21804 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | MD VETERANS CEMETERY | 12/04/2003 | HURLOCK, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Dennis D. Kelly | BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY MARYLAND 21804 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CORONARY ARTERY DISEASE | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) ASST.LIVIN |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D55006 | DECEMBER 1, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MOHAN BHAT, MD 614-B EASTERN SHORE DRIVE, SALISBURY MD 21804

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 02 2003 | Geneva G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41012

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): TIMOTHY A. RICHARDSON
2. Date of Death: Month 11 Day 22 Year 03
3. Time of Death: 10:32 AM
4a. Facility Name (If not institution, give street and number): 4422 NORFEN RD.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 212-86-0988
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 37 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07-31-1966
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4422 Norfen Rd
10f. Zip Code: 21227
10g. Citizen of What Country?: US

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): None
16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): William Richardson
18. Mother's Name (First, Middle, Maiden Surname): Patricia Tabeling

19a. Informant's Name/Relationship (Type, Print): Patricia Rush - mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 68 Hitch Pond Circle, Seaford, DE 19973

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Capitol Crematory
Date: 11-25-2003
20c. Location - City or Town, State: Dover, DE

21. Signature of Funeral Service Licensee: John A. Cranston
22. Name and Address of Facility: Cranston Funeral Home, P O Box 967, Seaford, DE 19973

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. HYPOXIC BRAIN INJURY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): AIRWAY OBSTRUCTION
c. Due to (or as a consequence of): SELF HANGING
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death:

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year): 11-22-03
28b. Time of Injury: 10:32A M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: HANGING BY NECK
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 4422 NORFEN RD BALT

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Francesco Grasso MD
29c. License number: D 38363
29d. Date signed (Month, Day, Year): 11-24-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCESCO GRASSO MD 6569 N. CHARLES ST. TOWSON

2 DQ

**State Registrar**

31. Date filed (Month, Day, Year): NOV 26 2003
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 17 Rev 1/2001

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41013

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Raymond Ransey | November 26, 2003 | 1:30P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| FREDERICK MEMORIAL HOSP. | FREDERICK | FREDERICK |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 289-56-6242 | 1 ☒ M 2 ☐ F | 47 Yrs. | | | SEPT. 12, 1956 | TOLEDO OHIO |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | FREDERICK | FREDERICK | 1 ☒ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2 LIVINGSTONE TERR. | 21702 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 2yrs. | CONSTRUCTION | FOLAND CONST. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| WILLIE RANSEY | VELMA MCGEE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| TANISHA RANSEY DAUGHTER | 2020 10th ST. DES MOINES IA. 50314 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Smithsburg Crem | 12-3-03 | Smithsburg MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gary L. Rollins | GARY L. ROLLINS FUNERAL HOME 110 W. South ST. FREDERICK, MD. 21701 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cerebral Infarct | 5 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D57647 | 11/26/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ernest Clevinger, MD 187 Thomas Johnson Dr. Frederick MD 21702

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC - 3 2003 | ▶ Donna G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#20b perFH 12/18/03 FW
Item#24aperVERBAL,Item#30perDVRG826

# Certificate of Death

Reg. No. 2003 41014

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Dalbert | George | Rager | December 11, 2003 | 20:31 pm |

| 4a. Facility Name (If not institution, give street end number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Shady Grove Hospital | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 179-28-2649 | 1☒M 2☐F | 68 Yrs. | | | Nov. 15,1935 | PA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Montgomery | Gaithersburg | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12221 Morning Light Terrace | 20878 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | President | Utility Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Albert Rager | Mildred Fisher |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Freda J. Rager - Wife | 12221 Morning Light Terr. Gaithersburg, MD 20878 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chestnut Grove Cemetery | 12/18/03 | Herndon, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Chris Adams | Adams-Green Funeral Home 721 Elden St., Herndon, VA 20170 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28e-i show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. acute dysrhythmia | minutes |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

hypercholesterolemia

Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D53887 | December 11, 2003 |

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Orlee Panitch MD Shady Grove Hospital Rockville,Md

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 18 2003 | ▶ |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41015

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Rose Elizabeth Rothwell | December 6 2003 | 0240 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Union Hospital | Elkton | Cecil |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 198-26-4008 | 1☐ M 2☒ F | 82 Yrs. | | | DEC 27, 1920 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Cecil | Elkton | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 38 Pinder Avenue | 21921 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | In Her Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William M. Wilhelm | Adeline Devine |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Frank W. Rothwell/Husband | 38 Pinder Avenue, Elkton, Maryland 21921 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | R.A. Ferris & Co. Inc. | December 8, 2003 | West Chester, Pennsylvania |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Donna S. Hicks | Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Aspiration Pneumonia | Unknown |
| | Due to (or as a consequence of): | |
| | b. Chronic Obstructive Pulmonary Disease | Unknown |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☑ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Hypothyroidism

23e. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☑ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Sachdev S MD | D0023322 | 12.8.03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.S. SACHDEV MD, 118 North St Suite 3B, Elkton MD 21921

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 18 2003 | ▶ [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41016

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| | | | |
|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): ROY ROOSEVELT STEWART | | 2. Date of Death (Month, Day, Year): NOV. 28, 2003 | 3. Time of Death: 8:00 PM |
| 4a. Facility Name (If not institution, give street and number): DEVLIN MANOR NURSING HOME | 4b. City, Town, or Location of Death: CUMBERLAND | 4c. County of Death: ALLEGANY | |
| 5. Social Security Number: 023-28-0091 | 6. Sex: 1☒ M 2☐ F | 7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min. |
| 8. Date of Birth (Month, Day, Year): MAR. 19, 1933 | 9. Birthplace (State or Foreign Country): WEST VIRGINIA | | |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| WV | MINERAL | RIDGELEY | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8 THIRD AVENUE | 26753 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Year or Dates: KOREA | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | SELF-EMPLOYED | CONSTRUCTION |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| GUY WILLIAM STEWART | MAMIE ARNOLD |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| PATRICIA STEWART / WIFE | P.O. BOX 447 - RIDGELEY, WV 26753 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | EBENEZER CEMETERY | 12/02/2003 | ROMNEY, WV |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Upchurch Funeral Home | UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Lung cA | > 1 year. |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| Due to (or as a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of Certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Shiv Khanna | D0054001 | 12/4/3. |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shiv C Khanna 1321-E National Highway LaVale MD 21502

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 05 2003 | Brenda G Sparks |

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41017

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Arthur | Stull | December 2, 2003 | 7:58 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Edenton Retirement Center | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-16-1199 | 1☒ M 2☐ F | 91 Yrs. | | | March 19, 1912 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5800 Genesis Lane | 21703 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | Owner | Stull Grocery |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| Frederick S. Stull | Dona Wachter |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| James A. Stull, Sr. - son | 21821 Big Woods Road, Dickerson, Maryland 20842 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Mt. Olivet Cemetery | 12-4-2003 | Frederick, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Sharon Camille Cline | Stauffer Funeral Homes, P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive heart failure | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): ds Chronic heart disease | years |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D 27101 | December 3, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Lloyd H. Halverson MD, 1475 Taney Ave Frederick md 21702

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC - 4 2003 | Geneva G Sparks |

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

5

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41018

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Arthur Milton Stonesifer
2. Date of Death (Month, Day, Year): December 1 2003
3. Time of Death: 4:33 PM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 168-14-3184
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Dec. 11, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Thurmont
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 8 Stull Drive
10f. Zip Code: 21788
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator
16b. Kind of Business/Industry: Gas Station

17. Father's Name (First, Middle, Last): John Stonesifer
18. Mother's Name (First, Middle, Maiden Surname): Fannie Myers

19a. Informant's Name/Relationship (Type, Print): Eva Stonesifer/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Stull Drive, Thurmont, MD 21788

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Frederick Crematory
Date: 12/3/2003
20c. Location - City or Town, State: Frederick, MD 21788

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Stauffer Funeral Home, PA 104 E. Main St. Thurmont, MD 21788

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. BRAIN Edema

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. Intracerebral Bleed
Due to (or as a consequence of): c. Hypertension
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Prafulla Dave
29c. License number: D20922
29d. Date signed (Month, Day, Year): 12/1/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Prafulla Dave 188 Thomas Johnson, Frederick, md 21702

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**State Registrar**

31. Date filed (Month, Day, Year): DEC - 2 2003
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2003 41019

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Mary Lillian Schmidt | November 30 2003 | 4:29P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Frederick Memorial Hospital | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-42-2777 | 1☐M 2☒F | 59 Yrs. | | | May 5, 1944 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Mt. Airy | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 206 Plainview Avenue | 21771 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Seamstress | Shirt Factory |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Esworthy | Frances Evans |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Alfred Schmidt/ Husband | 206 Plainview Avenue, Mt. Airy, MD 21771 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Pine Grove Cemetery | 12-4-03 | Mt. Airy, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD. 21701 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ISCHEMIC CARDIOMYOPATHY — Approximate Interval: 5YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD - Chronic Obstructive Pulmonary Disease

Rheumatoid Arthritis

Peripheral Vascular Disease

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) — Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Joseph Ashwal MD | D26609 | 11/30/03 5PM |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Joseph Ashwal 56 Thomas Johnson Dr. Frederick, MD 21702

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC - 2 2003 | Donna G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41020

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| May V. Shank | November 30, 2003 | 11:43 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| College View Center | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-36-2529 | 1☐M 2☒F | 63 Yrs. | | | Feb. 9, 1940 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9114 Bethel Road | 21702 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | Cashier | Department Store |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles M. Bartholow, Sr. | Helen V. Poole |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| V. Charmaine Vaughn / Daughter | 10730 Powell Rd. Thurmont, Maryland 21788 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment | Mount Olivet Cemetery | 12-3-03 | Frederick, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Courtney Mathis | Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC LUNG CANCER | 1 mos |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. SMALL CELL LUNG CANCER | 1 YEAR |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D-31912 | 12/01/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JULIO MENOCAL MD - 1564 OPOSSUMTOWN PIKE, FREDERICK, MD 21702

12

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC - 2 2003 | ▶ Jeanne G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar WiCHD, dq Amend#26, 11-27-03, PerPHY

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41021

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| MARION DALBY SHREEVES | NOVEMBER 24 2003 | 5:10 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 922 BROWN STREET | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 228-48-1262 | X 1 M 2 F | 62 Yrs. | | | 04/04/1941 | CAPE CHARLES, VA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | WICOMICO | SALISBURY | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 922 BROWN STREET | 21804 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | GEN/MANAGER VICE PRESIDENT | ELECTRIC MOTORS |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| PAIGE TURNER SHREEVES | MAUDE MARIAN DALBY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| DARLENE J. SHREEVES-SPOUSE | 922 BROWN STREET, SALISBURY, MARYLAND, 21804 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | WICOMICO MEM. PARK | 11/28/2003 | SALISBURY, MARYLAND |

21. Signature of Funeral Service Licensee ▶ Scott L. Bounds

22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC ADENOCA of COLON

Due to (or as a consequence of):
b. LIVER METASTASIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 Inpatient ~~2 ER/Outpatient~~ 3 DOA
Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Fauzi Khalil, MD | D 38647 | 11-25-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FAUZI KHALIL, 1325 MT. HERMON RD, SALISBURY, MD 21804

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| NOV 26 2003 | ▶ Jennie D Sparks |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5 DQ

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41022

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Anna Belle STRUBE | | | November 26, 2003 | 9:35 PM M |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | |
| Wilson Health Care Center | Gaithersburg | | Montgomery | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-05-5762 | 1☐M 2☒F | 88 Yrs. | | | July 17, 1915 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Gaithersburg | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 303 Woodland Road | 20877 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Sales Clerk | Department Store |
| | 1 | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Leicester Thomas, Sr. | Pearl Brown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Carole O. Shreve, daughter | 303 Woodland Road, Gaithersburg, MD 20877 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mount Olivet Cemetery | Dec. 1, 2003 | Frederick, Maryland |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| ▶ Richard E. Dry | M00255 | Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | 15 YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D31563 | NOVEMBER 28, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHARLES M. BENNER MD 201 RUSSELL AVENUE, GAITHERSBURG, MD 20877

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC - 1 2003 | ▶ Geneva G Sparks |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41023

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| William Howard Schumacher II | November 24 2003 | 11:35 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 7021 Marriottsville Road | Marriottsville | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 472-24-0819 | 1☒M 2☐F | 76 Yrs. | | | Nov 14 1927 | MN |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Carroll | Marriottsville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7021 Marriottsville Road | 21104 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? / If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Bleck, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | ☒Yes 2☐No 1946 1947 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Computer Systems Analyst | Department of Health and Human Services |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William H. Schumacher, Sr. | Clara Rodekhur |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jim Schumacher/son | 4340 Middleburg Road Union Bridge, MD 21791 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Highland View Cem | 11/29/2003 | Berrett, MD |

21. Signature of Funeral Service Licensee: John K [illegible]

22. Name and Address of Facility: Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ADENOCARCINOMA OF THE PANCREAS | 5 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D22220 | November 25, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ellis Mez Md 1645 Liberty Road Eldersburg, MD 21784

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| NOV 26 2003 | [signature] |

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ORIGINAL

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Cov 10

Amended Item 20b per F.D. 12/01/2003 Carroll County, wjl

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41024

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| RAYMOND WALLACE SHELTON, SR. | NOVEMBER 28, 2003 | 9:16 AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| CARROLL HOSPITAL CENTER | WESTMINSTER | CARROLL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-14-2851 | 1☐M 2☐F XX | 88 Yrs. | | | NOVEMBER 7, 1915 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | CARROLL | TANEYTOWN | 1☒Yes 2☐No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 50A EAST BALTIMORE STREET | 21787 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed XX 4☐Divorced | ~~XX~~Yes 2☐No If Yes, Give Year or Dates: WWII/KOREA | 1☐Yes ~~3☒~~No XX Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | LABORER | FACTORY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JAMES WILLIAM SHELTON | MARTHA ESTELLA MCKINLEY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| RAYMOND W. SHELTON, JR./SON | 50A EAST BALTIMORE ST, TANEYTOWN, MD 21787 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial XX 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | GARRISON FOREST VET. ~~CEMETERY~~ CEMETERY | 12/4/03 | OWINGS MILLS, MARYLAND |

21. Signature of Funeral Service Licensee: Justin R. Shelton

22. Name and Address of Facility: MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, MD 21157

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. COPD | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HTN

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23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| M.D. | D0054580 | 12/1/3 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WASSIM FAKHAR, M.D. 417 EAST BALTIMORE STREET, TANEYTOWN, MD 21787

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 0 1 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

SHELTON, RAYMOND

WJL 1

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41025

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| WANDA ANDERSON SCOTT | Nov. 26, 2003 | 5:05 pm |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 204 South Main St. | Berlin | Worcester |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 273 24 1196 | 1☐ M 2☒ F | 83 Yrs. | | | Jan. 16, 1920 | Ohio |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Worcester | Berlin | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 204 South Main St. | 21811 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Nurse | Hospital/Health Care |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Anderson | Ida Gilson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dr. Paul A. Scott, M.D. | 10168 Waterview Dr. Ocean City, MD 21842 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | St. Paul's Churchyard | 11/29/2003 | Berlin, MD |

21. Signature of Funeral Service Licensee: ▶ H. Bird Burbage

22. Name and Address of Facility: The Burbage Funeral Home 108 William St. Berlin, MD 21811

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ASCVD | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): SEVERAL YRS | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☒ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Dorothy C. Holzworth M.D. | D 06241 | 11-29-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL, MD. 21863

C.H. 6

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 02 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41026

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|
| Margaretta | Strandwitz | 12 | 8 | 2003 | 4:12 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Catherine's Nursing Center | Emmitsburg | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 165-14-3994 | 1☐M 2☒F | 85 Yrs. | | | Jun 18, 1918 | New Jersey |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1341 Butterfly Lane | 21703 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Bank Teller | Financial Institution |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Truman Fritz | Esther Browning |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs Christine B. Pappas/Daughter | 1341 Butterfly Lane, Frederick, Maryland 21703 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Smithsburg Crematory | Dec 9, 2003 | Smithsburg, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Karen Lynn Robaw M00706 | Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Dementia with Progressive decline | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | DS8391 | 12-09-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAJJAD AZIZ, MD. 801- TOLL HOUSE AVE, Frederick MD 21701

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 18 2003 | Jennifer G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41027

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Karen Sisson | December 12 2003 | 9:43 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical Center | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-40-0812 | 1☐M 2☒F | 61 Yrs. | | | 11-4-1942 | New York |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Edgewood | 1☐Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1303 Edgewood Road | 21040 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☐No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Manufacturing | Manufacturing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Small | Ellen Bailey |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| David Sisson - Son | 562 Jamestown Court Edgewood, Md 21040 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gardens of Faith | 12/16/03 | Baltimore, Md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Kenneth B. Cargo, | Tarring-Cargo Funeral Home, P.A 333 S. Parke St. Aberdeen, Md 21001 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Intra cerebral hemorrhage | 3days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☐No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | P16551 | December 12 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nicholas Szerlip 22 South Greene street Baltimore MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 18 2003 | |

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-I show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41028

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Robert Daniel SWANK, SR. | 12 / 08 / 2003 | 4:30 P.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 12913 Unger Road | Smithsburg | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 203-10-2012 | 1☒M 2☐F | 87 Yrs. | | | 5-10-16 | PA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Washington | Smithsburg | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12913 Unger Road | 21783 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 years | | Fleet Mechanic | Koontz Dairy |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph Henry Swank | May Violet Hambright |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Robert D. Swank, Jr. | 12913 Unger Road, Smithsburg, MD 21783 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Lincoln Cemetery | 12-13-2003 | Chambersburg, PA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Dennis Davis | Davis Funeral Home, Pennsylvania Ave., Smithsburg, MD 21783 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Coronary Artery Disease | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure — Prostate Carcinoma
Chronic Renal Failure — Obstructive Sleep Apnea
Type 2 Diabetes Mellitus

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ William A. Kramer MD | MD024313 | 12/10/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William A. Kramer MD 144 S. 8th St. Chambersburg Pa. 17201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 18 2003 | ▶ Bonnie G Sparks |

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2003 41029

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Elsie Irene Smith
2. Date of Death (Month, Day, Year): Dec 7, 2003
3. Time of Death: 4:53 am M
4a. Facility Name (If not institution, give street and number): 415 Piedmont Avenue
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 218163783
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 20, 1925
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 415 Piedmont Avenue
10f. Zip Code: 21502
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Harley Brant
18. Mother's Name (First, Middle, Maiden Surname): Minnie (unknown)

19a. Informant's Name/Relationship (Type, Print): Patricia Spriggs daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 415 Piedmont Avenue Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rose Hill Cemetery
Date: 12/10/2003
20c. Location - City or Town, State: Cumberland MD

21. Signature of Funeral Service Licensee: James T. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Small cell cancer of Lung — 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery Disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D0033280
29d. Date signed (Month, Day, Year): Dec 10, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sunil Gupta M.D. 625 Kent Avenue Cumberland MD 21502

**State Registrar**

31. Date filed (Month, Day, Year): DEC 18 2003
32. Registrar's Signature: Jennifer B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospitel or Attending Physicien:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funerel Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41030

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lena Rhoda Schwenninger
2. Date of Death: Month DECEMBER Day 9, Year 2003
3. Time of Death: 11:10A M
4a. Facility Name (If not institution, give street and number): RAVENWOOD LUTHERAN VILLAGE
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

**Funeral Director**

5. Social Security Number: 214-36-6869
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 5,1915
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 21643 Black Rock Road
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Brady Leasure
18. Mother's Name (First, Middle, Maiden Surname): Miriah Willet

19a. Informant's Name/Relationship (Type, Print): Mary C.Youngblood/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21643 Black Rock Road Hagerstown, MD 21740

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Date: 12/10/03
20c. Location - City or Town, State: Smithsburg, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: 141 West Main Street Grove Funeral Home,P.A. Hancock,MD 21750-0368

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 2 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. cardiac arrhythmia Pulmonary Disease — yrs
Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Acute Abdomen Acute Renal Failure
Atherosclerotic Cardiovascular Disease
Mild Dementia Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D18019
29d. Date signed (Month, Day, Year): DEC 9, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VASANT DATTA, MD 340 MILLST HAGERSTOWN MD 21740

**State Registrar**

31. Date filed (Month, Day, Year): DEC 18 2003
32. Registrar's Signature: [signature]

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SCHWENNINGER, Lena Rhoda

DHMH 17 Rev 1/2001

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41031

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Norman Lee Taylor | November 27 2003 | 0851 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplece (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-42-7815 | 1 [X] M 2 [ ] F | 58 Yrs. | | | Jan 1, 1945 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Worcester | Snow Hill | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 104A Stevens St. | 21863 | U.S. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Driver | Poultry |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Linwood Taylor, Sr. | Edna Manuel |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Bernadine V. Taylor/wife | 104A Stevens St., Snow Hill, MD 21863 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Coolspring UMC Cemetery | 12/2/2003 | Girdletree, MD |

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility
Lewis N. Watson Funeral Home
1618 West Road, Salisbury, MD 21801

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Intracranial bleeding | Hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): End-Stage Renal Failure | Years |
| | c. Due to (or as a consequence of): Hypertension | Years |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DM

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 [ ] Yes 2 [ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | 16725 | 11/28/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TAN, CONSTANTE 1340 S. Division St., Salisbury, MD 21801

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 01 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Norman Taylor 219-42-7815

Norman Taylor

4DQ

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41032

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| NOVELLA MAE TAYLOR | 11 / 12 / 03 | 6:44 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ATLANTIC GENERAL HOSPITAL | BERLIN | WORCESTER |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-20-8006 | 1☐ M 2☒ F | 77 Yrs. | | | Feb. 2, 1926 | Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Worcester | Snow Hill | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 119 West Martin Street | 21863 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8th | | laborer | Domestic |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CHARLIE B. DIX | AUDREY WISE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Theressa King/daughter | 422 A Dighton Avenue - Snow Hill, MD 21863 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | St. James Cemetery | 11/18/2003 | Snow Hill, Maryland |

| 21. Signature of Funeral Service License | 22. Name and Address of Facility |
|---|---|
| Patricia Jolley | JOLLEY MEMORIAL CHAPEL 1213 Jersey Road - Salisbury, MD 21801 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. congestive heart failure | 3 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. amyloidosis | 1 month |
| | c. | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Physician | H44283 | 11/12/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert Dirks 9733 Heritway Drive Berlin, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| NOV 24 2003 | Penina B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

Taylor Novella 218-20-8006

3 MP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41033

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| CHARLES TROUT | November 26 2003 | 10:45P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Catherine's Nursing Home | Emmitsburg | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-36-0410 | 1 X M 2 ☐ F | 80 Yrs. | | | Nov. 12, 1923 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Frederick | Thurmont | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 509 Woodland Ave. | 21788 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Farmer | Dairy |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harry Trout | Hallie Crum |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Anna Mae Trout - wife | 509 Woodland Ave., Thurmont, MD 21788 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Union Cemetery | 12/1/2003 | Keysville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Catharine O. Hartzler | Hartzler Funeral Home 404 S. Main St., Woodsboro, MD |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | |
| | Due to (or as a consequence of): SEPSIS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D 58391 | 11-26-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAJJAD AZIZ, MD. 801 TOLLHOUSE AVE, SUITE-C 3, Frederick, MD 21701

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 0 2 2003 | ▶ Teresa L. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-i show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 8

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41034

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Evelyn | Marie | Taylor | November 28, 2003 | 8:30PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3039 Brinkley Road Apt. T-2 | Temple Hills | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplece (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 463-74-8669 | 1☐M 2☒F | 55 Yrs. | | | March 28,1948 | Texas |

Usual Residence of Decedenl

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George's | Temple Hills | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whal Country? |
|---|---|---|
| 3039 Brinkley Road Apt T-2 | 20748 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedenl of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: African American |

| 15. Decedenl's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 5 + | Social Worker | Social Services |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lorenzo Gregon, Sr. | Gladys E. Connor |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jacquelyn Taylor-Mitchell (Daughter) | 721 D Shipper Ct. Colts Neck, New Jersey 07722 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Dorris Miller Cemetery | Dec 16, 2003 | Waco, Texas |

21. Signature of Funeral Service Licensee: Mark D. Parker #00153

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandra Ferry Road Clinton, MD20735

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications lhal caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresl, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | |
| Sequenlially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lasl | b. Due lo (or as a consequence of): | |
| | c. Due lo (or as a consequence of): | |
| | d. Due lo (or as a consequence of): | |

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part If. Dther significant conditions conlributing lo death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

Diabetes mellitus

23e. Did tobacco use conlnbule lo the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatienl 2☐ER/Outpatienl 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accidenl 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury M | 28c. Injury al Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, farm, slreet, faclory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On lhe basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| Elwin Bustos | 42936 | DEC. 5, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elwin Bustos, M.D. 1160 Varnum St. DePaul Bldg. Suite 213 Washington, DC

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | Steven H Spader |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41035

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Baby Boy Thompson
2. Date of Death (Month, Day, Year): September 4, 2003
3. Time of Death: 0123 M
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: NONE
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday) Yrs.: If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.: 9
8. Date of Birth (Month, Day, Year): September 4, 2003
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 3503 Fairview Road
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Infant
16b. Kind of Business/Industry: Infant

17. Father's Name (First, Middle, Last): Antonio Jones
18. Mother's Name (First, Middle, Maiden Surname): Belinda Thompson

19a. Informant's Name/Relationship (Type, Print): Belinda Thompson (mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3503 Fairview Road Baltimore, MD 21207

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Johns Hopkins Hospital
Date: September 4, 2003
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: 600 North Wolfe Street Johns Hopkins Hospital Baltimore, MD 21207

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Extreme Prematurity — 9 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): X 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D43683
29d. Date signed (Month, Day, Year): 9/4/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jessica Brenstock, 600 North Wolfe Street Baltimore, Maryland 21205

**State Registrar**

31. Date filed (Month, Day, Year): DEC 18 2003
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Thom Baby Boy BB- Belinda

K.B

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41036

Physician /Medical Examiner

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Lorraine | Virginia | Ullery | DECEMBER 05, 2003 | 00:27 a.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Memorial Hospital | CUMBERLAND | ALLEGANY |

Funeral Director

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-48-9154 | 1☐M 2☒F | 77 Yrs. | | | 01/26/1926 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Allegany | Cumberland | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11205 Sunrise Avenue | 21502 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Homemaker | Homemaker |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Harrison Greenawalt | Virgie Ellen Roland |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Marvin L. Ullery / husband | 11205 Sunrise Avenue, Cumberland, MD 21502 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Sunset Memorial Park | 12/09/2003 | Cumberland, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Robert C. Adams | Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 |

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Probable Acute Myocardial Infarction | 1hour |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D33280 | DECEMBER 6, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil Gupta M.D. 625 Kent Avenue Cumberland, Maryland 21502

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 08 2003 | Linda G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41037

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Marie | Youngs | Vogel | Nov. | 25 | 2003 | 16:45 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | Wicomico |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 007-60-4520 | 1☐ M 2☒ F | 45 Yrs. | | | | | June 11, 1958 | California |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Salisbury | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 307 Park Avenue | 21801 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4+ | Consultant-Perdue School of Business | Salisbury University |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph Patrick Youngs | Mary ----- Stone |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joseph J. Vogel - Husband | 307 Park Avenue, Salisbury, Maryland 21801 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Salisbury Crematory | 11/26/2003 | Salisbury, Maryland |

21. Signature of Funeral Service Licensee: ▶ Keith R Dewey CFSP

22. Name and Address of Facility: Holloway Funeral Home, Professional Association 501 Snow Hill Road, Salisbury, Maryland 21804

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Multiple Myeloma | 3 months. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature], M.D. | D30690 | Nov. 25, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James E. MARTIN, M.D., 145 E. Carroll St., Suite A-1, Salisbury, MD 21801

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 02 2003 | ▶ [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Marie Vogel 007-60-4520

10 DQ

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41038

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Rose Maude Wood | December 9 2003 | 1205 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Memorial Hospital | Easton | Talbot |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-50-5505 | 1☐M 2☒F | 85 Yrs. | | | April 16, 1918 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Caroline | Ridgely | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11251 Downes Station Road | 21660 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Caucasian |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Homemaker | Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William John Shortall | Maude Ethel Andrews |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| W. Kenneth Wood Son | 24321 Shore Highway, Denton, Maryland 21629 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Holy Cross Cemetery | 12/13/2003 | Greensboro, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Randolph L. Moore | Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 1 month |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Congestive Heart failure | 2 weeks |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D0051132 | 12-9-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jorge Abrego, M.D., 598 Cynwood Drive, Easton, Maryland 21601

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 10 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Rose Wood

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41039

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Esther | Wellisch | December 1, 2003 | 9:45 A.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Glade Valley Nursing Home | Walkersville | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 124-10-0445 | 1☐ M 2☒ F | 86 Yrs. | | | Jan 7, 1917 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Adamstown | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2995 Hope Mills Lane | 21710 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☐ No If Yes, Give Year or Dates: X | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Manager | Western Union |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Mayer Zawadsky | Gussie Lamonier |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Harriet Mac Farland - Daughter | 2995 Hope Mills Lane, Adamstown, Maryland 21710 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify) | Beth David Memorial | 12-3-2003 | Hollywood, Florida |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimers disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D26516 | December 1, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Allen J. Gilson, M.D, 1475 Taney Avenue, Frederick, Maryland 21702

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC - 2 2003 | ▶ Geneva G Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41040

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Granville T. Whaley

2. Date of Death: Month November Day 27 Year 2003

3. Time of Death: 1125 M

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 222-09-3170

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-10-1918

9. Birthplace (State or Foreign Country): DE.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: De.

10b. County: Sussex

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14975 Woody Rd.

10f. Zip Code: 19956

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): John Raymond Whaley, Jr.

18. Mother's Name (First, Middle, Maiden Surname): Ruth Hastings Whaley

19a. Informant's Name/Relationship (Type, Print): Woodrow Whaley, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14985 Woody Rd. Laurel, De. 19956

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Odd Fellows Cem.

Date: 11-30-03

20c. Location - City or Town, State: Laurel, De.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Prostate Carcinoma

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D54127

29d. Date signed (Month, Day, Year): 11/27/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan Davis MD 303-106 Milford St. Salisbury MD 21804

**State Registrar**

31. Date filed (Month, Day, Year): DEC 02 2003

32. Registrar's Signature: [signature] G Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Granville Whaley 222-09-3170

12 mm

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41041

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| THOMAS G. WHITE | NOV 21 2003 | 17:04 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-22-7382 | 1 X M 2 ☐ F | 75 Yrs. | | | 02/15/1928 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | WICOMICO | SALISBURY | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 330 EAST VINE STREET | 21804 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | PAINTER | WICOMICO COUNTY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| THOMAS G. WHITE | ESTHER E. BROUGHTON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| LINDA MEESE - DAUGHTER | 216 NEW YORK AVENUE, SALISBURY, MARYLAND 21804 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | MARYLAND VET. CEM. | 11/25/2003 | HURLOCK, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Dennis S. Kelly | BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Respiratory Failure | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Severe COPD | 30 years |
| | Due to (or as a consequence of): c. Atrial Fib | 2 yrs |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and Title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ John McLean MD | D25209 | 11/21/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. John McLean 1315 S. Division St. Salisbury Md. 21804

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| NOV 24 2003 | Penny G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Thomas White 213-22-7382

IVA

Heather Williams
03-07419
RJD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41042

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| HEATHER | LYNN | WILLIAMS | November 21, 2003 | 2200P. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Nanticoke Road and Centenial Drive | Salisbury | Wicomico |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-06-5043 | 1☐ M 2☒ F | 27 Yrs. | | | April 22,1976 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Salisbury | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1400 E. Upland Drive | 21801 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No *Specify:* | *Specify:* white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 1 | Housewife | Domestic |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Patrick Davis | Karen Young |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Doug P. Williams/husband | 6232 Ayrshire Dr., Salisbury, MD 21801 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Williams Family Cemetery | 11/26/03 | Hebron, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| David A. Thompson, CFSP | Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 |

To Be Completed by Funeral Director

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. MULTIPLE INJURIES | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☒ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☐ No | 1☑ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) (Scene) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☑ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | 11-21-03 | 2100P M | 1☐ Yes 2☑ No | DRIVER OF AN COLLISION WITH CAR |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| ROADWAY | NANTICOKE RD AND CENTENNIAL DR NICHOLS |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Marjorita A. Korell MD | O.C.M.E. | November 22, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARJORITA A. KORELL 111 Penn Street, Baltimore, Maryland 21201

10 DD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| NOV 25 2003 | Geneva G Sparks |

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41043

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| CHARLES | B | WOOD | November 23 2003 | 3:20 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Wicomico Nursing Home | Salisbury | Wicomico |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-16-5066 | 1☒M 2☐F | 85 Yrs. | | | November 23,1918 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Salisbury | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 900 Booth Street | 21804 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: WW II | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | — | Deli manager | Acme Markets |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frank Wood | Ethel Thompson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lynn Chodnicki/daughter | 3976 Featherstone Dr., Salisbury, MD 21804 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment | Louden Park Cemetery | 11/28/03 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Keith R Dewey CFSP | Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No |
|---|---|

| 25. Was case referred to medical examiner? 1☐Yes 2☒No | 26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |
|---|---|

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ | DJ5006 | NOVEMBER 24, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohan Bhat, M.D. 614 Eastern Shore Drive, Salisbury, MD 21801

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| NOV 26 2003 | ▶ Jessica G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-I show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CHARLES Wood

WA

4DG

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41044

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Robert Dunham Wood | November 26, 2003 | 7:20 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 11020 Putman Road | Thurmont | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-46-7691 | 1☒M 2☐F | 56 Yrs. | | | April 23, 1947 | Pennsylvania |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Thurmont | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11020 Putman Road | 21788 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1967 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Craftsman | Custom Fabrication |
| | 1 | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Robert Shoecraft Wood | Dorothy Dunham |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Susan Margaret Wood / Wife | 11020 Putman Rd., Thurmont, MD 21788 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Resthaven Crematory | November 27, 2003 | Frederick, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Resthaven Funeral Services, Skkot Cody P.A, 9501 Catoctin Mtn. Hwy. Frederick, MD 21701

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Colorectal Cancer | Months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cancer Cachexia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] A-2 HEGAZI, MD | D44164 | November 27, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amr Z. Hegazi, M.D. 46 B Thomas Johnson Drive; Frederick, MD 21702

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC - 1 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41045

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ethel Mosner Williams
2. Date of Death (Month, Day, Year): November 25, 2003
3. Time of Death: 12:45 pM
4a. Facility Name (If not institution, give street and number): Chapel Hill Nursing Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-24-6897
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 28, 1927
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Finksburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1814 Hoff Lane
10f. Zip Code: 21048
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vice President
16b. Kind of Business/Industry: Banking
17. Father's Name (First, Middle, Last): Jason Mosner
18. Mother's Name (First, Middle, Maiden Surname): Lillian Maxwell
19a. Informant's Name/Relationship (Type, Print): Wilbur L. Williams, husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1814 Hoff Lane, Finksburg, MD 21048
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet.
Date: 12/02/2003
20c. Location - City or Town, State: Owings Mills, MD
21. Signature of Funeral Service Licensee: Steven W Eline MD0723
22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Enterococcal bacteremic sepsis.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Non-oliguric Acute Renal Failure.
Due to (or as a consequence of):
c. CVA c Dysphagia.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PEA. GERD. Ha s/p with a ruptured Hge aneurysm.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: S. Sidwig MD
29c. License number: D30119
29d. Date signed (Month, Day, Year): 11/26/03
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shahida Sirnigi 6212 Sykesville Road SYKESVILLE, MARYLAND 21784

WJZ 6

**State Registrar**

31. Date filed (Month, Day, Year): DEC 01 2003
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41046

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JOSEPH LINWOOD WHITE, JR. | December 5, 2003 | 0452 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 223-24-6740 | 1 [X] M 2 [ ] F | 80 Yrs. | | | 04/25/1923 | NEW JERSEY |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| VIRGINIA | ACCOMACK | ACCOMAC | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 23481 DRUMMONDTOWN ROAD | 23301 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: U.S. COAST GUARD | 1 [ ] Yes 2 [X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | POSTAL CLERK | U.S. GOVERNMENT |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOSEPH L. WHITE, SR. | LYDE ASHBY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOSEPH L. WHITE, IV/SON | 23471 DRUMMONDTOWN ROAD, ACCOMAC, VA 23301 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | EDGE HILL CEMETERY | 12/07/03 | ACCOMAC, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| John T. Williams, Jr. | WILLIAMS FUNERAL HOME, 25046 PARKSLEY RD, PARKSLEY, VA 23421 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. MULTIPLE ORGAN FAILURE | 2-3 DAYS |
| Due to (or as a consequence of): | b. SYSTEMIC EMBOLIZATION DURING BYPASS SURGERY | 1 WEEK |
| Due to (or as a consequence of): | c. HEAVY ATHEROSCLEROSIS OF ASCENDING AORTA | YEARS |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D0053551 | 12/5/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES Todd MD 201 Pine Bluff Rd. Suite 25 Salisbury Md.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 08 2003 | |

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

Joseph White SS# 223-24-6740

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41047

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Robert L Wharton | 11 / 24 / 03 | 1647 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical Center | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 222-20-3465 | 1 [X] M 2 [ ] F | 69 Yrs. | | | 8-17-1934 | DELAWARE |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| DELAWARE | SUSSEX | LAUREL | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7251 AIRPORT ROAD | 19956 | US |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 4-30-54 4-8-58 | 1 [ ] Yes 2 [X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | AUTOMOTIVE SERVICE | AUTOMOTIVE SUPPLY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| WILLIAM C. WHARTON | CLARA E. DICKERSON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| BEULAH E. WHARTON/ WIFE | 7251 AIRPORT RD, LAUREL, DELAWARE. 19956 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | MELSON'S CAPE HENLOPEN CREMATORY | 11-25-03 | FRANKFORD, DELAWARE |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | MELSON FUNERAL SERVICES, LTD, LONG NECK RD, MILLSBORO, DE. 19966 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hepatic Necrosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No | 24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No |
|---|---|

| 25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No | 26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | P13360 | 11/24/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES R BEAMAN M.D. 22 South Greene St. Baltimore, MD 21201

ET 3+1

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 01 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41048

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Mildred | Jeanette | Wachter | December 15, 2003 | 615am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Vindabona Nursing Center | Braddock Heights | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-50-8283 | 1☐M 2☒F | 94 Yrs. | | | Dec. 15, 2003 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1403-B Key Parkway, #203 | 21702 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | self | homemakers |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Spencer Eugene Stup | Mary Ellen Easterday |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Frances Roney, daughter | 1403-B Key Parkway, #203, Frederick, MD 21702 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mt. Olivet Cemetery | 12/17/2003 | Frederick, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Ryan M. Berger M00999 | Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cerebrovascular Disease | 5 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Robert L. Kaufmann | D13971 | December 15, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Kaufmann, MD, 300 West Ninth Street, Frederick, MD 21701

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 18 2003 | ▶ Geneva B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41049

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GLENN C. WHITAKER

2. Date of Death (Month, Day, Year): December 10, 2003

3. Time of Death: 7:00 A M

4a. Facility Name (If not institution, give street and number): 73 Richardson Avenue

4b. City, Town, or Location of Death: Crisfield

4c. County of Death: Somerset

**Funeral Director**

5. Social Security Number: 400-36-3203

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): September 30, 1928

9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6503 Beechwood Road

10f. Zip Code: 21239

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): James Monroe Whitaker

18. Mother's Name (First, Middle, Maiden Surname): Mildred Crossman Gilmore

19a. Informant's Name/Relationship (Type, Print): Diana Ford (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 73 Richardson Avenue - Crisfield, MD 21817

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory

Date: 12/11/03

20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw, Jr.

22. Name and Address of Facility: Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, MD 21817

To Be Completed by Funeral Director

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC BLADDER CARCINOMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

TYPE II DIABETES

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Home of Daughter

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D 48098

29d. Date signed (Month, Day, Year): 12/10/2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817

Medical Certification: To Be Completed by Physician/Medical Examiner

**State Registrar**

31. Date filed (Month, Day, Year): DEC 18 2003

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

03-07639
CLARK M ZIRKLE
WHM

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41050

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| CLARK | MONROE | ZIRKLE | NOVEMBER 29, 2003 | 2:03 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 9080 EXECUTIVE CLUB DRIVE | DELMAR | WICOMICO CO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-46-8181 | [X] 1 M 2 F | 57 Yrs. | | | July 23,1946 | Washington, DC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Salisbury | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 501 Emory Court, Apt. 103 | 21804 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Army | 1 [ ] Yes 2 [X] No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4 | CPA | Accounting |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Glendon Zirkle | Laura Jenkins |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Anne L. Zirkle/wife | 501 Emory Court, Apt. 103, Salisbury, MD 21804 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Salisbury Crematory | 12/2/03 | Salisbury, MD |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Atherosclerotic cardiovascular disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [X] Yes 2 [ ] No | 1 [X] Yes 2 [ ] No |

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | O C M E | NOVEMBER 30, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

4+1VA JR

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 02 2003 | [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41051

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Mark | Zarick | December 11, 2003 | 1030am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 9502 Highlander Circle | Walkersville | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 289-54-8237 | 1[X] M 2[ ] F | 44 Yrs. | | | Sept 18, 1959 | Ohio |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 407 North Market Street | 21701 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 3 | Artist | Art |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Andrew Zarick | Antionette Marie Paletta |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Andrew Zarick, Jr/Brother | 9502 Highlander Circle, Walkersville, MD 21793 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[ ] Burial 2[X] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | Smithsburg Crematory | Dec 12, 2003 | Smithsburg, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Kathryn R Beeson M00706 | Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. End Stage Autoimmune Disease | Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Rectal Squamous Cell | Years |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1[ ] Yes 2[ ] No 9[ ] Unknown | 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Failure to thrive

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1[ ] Yes 2[X] No | 1[ ] Yes 2[ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1[ ] Yes 2[X] No | Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA | Other: 4[ ] Nursing Home 5[ ] Residence 6[X] Other (Specify) Brothers Home |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | | M | 1[ ] Yes 2[ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J. Allen Reilly MD | D54749 | December 11, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Allen Reilly, M.D., 801 Toll House Avenue, D-1, Frederick, Maryland 21701

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 18 2003 | Geneva G Sparks |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41052

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARGARET E. AMOS
2. Date of Death (Month, Day, Year): December 13 2003
3. Time of Death: 2:10 a M
4a. Facility Name (If not institution, give street and number): MANOR CARE-RUXTON
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CO

**Funeral Director**

5. Social Security Number: 216-34-5799
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 3 1938
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 6125 CHINQUAPIN PARKWAY
10f. Zip Code: 21239
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEKEEPER
16b. Kind of Business/Industry: DOMESTIC

17. Father's Name (First, Middle, Last): WILLIAM F. HUBBARD
18. Mother's Name (First, Middle, Maiden Surname): HATTIE McCLENDON

19a. Informant's Name/Relationship (Type, Print): Jacqueline Nixon/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6125 Chinquapin Pkwy, Baltimore, Md., 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT ZION CEMETERY
Date: 12-19-03
20c. Location - City or Town, State: LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee: Charles A Powell
22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. lung Cancer Metastatic to Brain

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Cyrus Asadi DO.
29c. License number: H0054424
29d. Date signed (Month, Day, Year): 12-16-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cyrus Asadi 7600 Osler Dr. Suite 205 Towson, MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41053

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Patricia Altman

2. Date of Death: Month Dec Day 12 Year 2003

3. Time of Death: 5:00 PM

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 199.20.2498

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): March 17, 1926

9. Birthplace (State or Foreign Country): Pennsylvania

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Fulton

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8216 Reservooir Rd.

10f. Zip Code: 20759

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): receptionist

16b. Kind of Business/Industry: retail

17. Father's Name (First, Middle, Last): John Albert Hesse

18. Mother's Name (First, Middle, Maiden Surname): Catherine Claire Canavan

19a. Informant's Name/Relationship (Type, Print): Mr. Lawrence Altman III Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8218 Reservoir Rd. Fulton, Maryland 20759

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: 12/16/2003

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service License: [signature] 1293

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute CVA with cerebral bleed — Approximate Interval Between Onset and Death: 1 day

Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. ____

Due to (or as a consequence of):

d. ____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coagulopathy

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D33627

29d. Date signed (Month, Day, Year): Dec 12, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 10724 Little Patuxent Pkwy Columbia, MD

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41054

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DELOIS BRISCOE
2. Date of Death (Month, Day, Year): December 15 2003
3. Time of Death: 1050A M
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-54-5148
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 52 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-13-1951
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1701 ELKTAW PLACE # 912
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSING ASSISTANT
16b. Kind of Business/Industry: HEALTH CARE

17. Father's Name (First, Middle, Last): ROSCOE BRYANT
18. Mother's Name (First, Middle, Maiden Surname): ELOIS TYSON

19a. Informant's Name/Relationship (Type, Print): MARVIN BRISCOE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1701 ELKTAW PL. #912, BALTO. MD 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DRUID RIDGE
Date: 12-22-03
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: Dwight C. Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Bilateral Pulmonary Consolidation — Approximate Interval Between Onset and Death:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cardiomegaly
Left Ventricular Hypertrophy
Right Ventricular Dilatation

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No
25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: 89508
29d. Date signed (Month, Day, Year): 12-15-03
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Catherine Lubwama c/o Maryland General Hospital

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: Penny P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#10bperFHG827 1/8/04 EW

# Certificate of Death

Reg. No. 2003 41055

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): Thelma Burroughs
2. Date of Deeth: Month 12 Dey 15 Year 03
3. Time of Death: 4:20 P.m
4a. Facility Name (If not institution, give street end number): GEC-R
4b. City, Town, or Location of Deeth: RANDALLSTOWN
4c. County of Deeth: BALT.

**Funeral Director**

5. Social Security Number: 277-38-4928
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-28-29
9. Birthplace (State or Foreign Country): MD

Usuel Residence of Decedent

10a. State: MD
10b. County: Baltimore ~~WINDSOR MILL~~
10c. City, Town or Location: WINDSOR MILL
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 3607 CLIFMAR RD.
10f. Zip Code: 21244
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grede completed)
Elementery/Secondery (0-12): 12 TH GRADE
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: EDUCATION

17. Father's Neme (First, Middle, Lest): DOC GEORGE ZEIGLER
18. Mother's Name (First, Middle, Maiden Surname): ELSIE MONROE

19a. Informant's Name/Reletionship (Type, Print): DEBBIE SMITH - WIGGINS
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 6715 WINDSOR MILL MD, BALTO. MD 21207

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREENMOUNT
Date: 12-19-03
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C. Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. METASTATIC ADENOCARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ UMA, M.D.
29c. License number: D0059107
29d. Date signed (Month, Day, Yeer): 12-15-2003

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): KALU UMA, MD WESTSIDE MEDICAL GROUP 2600 LIBERTY HEIGHTS AVENUE BALTIMORE, MD 21215

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: ▶ Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41056

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JAMES HARVEY BLACKWELL

2. Date of Death Month: December Day: 15 Year: 2003

3. Time of Death: 11:48 M

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-18-1339

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03-24-1918

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: RANDALLSTOWN

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 4270 MARYRIDGE DR.

10f. Zip Code: 21133

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7TH GRADE

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FLEET TECHNICIAN

16b. Kind of Business/Industry: AIR PORT

17. Father's Name (First, Middle, Last): HARVEY BLACKWELL

18. Mother's Name (First, Middle, Maiden Surname): CATHERINE OWENS

19a. Informant's Name/Relationship (Type, Print): DIANE JORDAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4270 MARYRIDGE DR., RANDALLSTOWN MD 21133

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST

Date: 12-23-03

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Wayne C

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — Approximate Interval: 8 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ryan C W Hall MD

29c. License number: Res 000

29d. Date signed (Month, Dey, Year): December 15, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ryan Hall MD 2401 West Belvedere Baltimore MD 21215

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature: George D Sparks

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Blackwell, James H

DHMH 17 Rev 1/2001

ORIGINAL

MARY BRANDON

UNK 03-330
03-7079
AKG

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene — 2003 41057

1- For State Registrar AMEND Item#21perFHG826 12/19/03 EW AMEND ITEM #20b PER FHG 828 2/04/04 JH

# Certificate of Death

Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Brandon

2. Date of Death Month Day Year: November 6, 2003

3. Time of Death: 11:15A M

4a. Facility Name (If not institution, give street and number): Northbound I-95 @ Mile Marker 904

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 231-01-9337

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 27, 1912

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Virginia

10b. County: N/A

10c. City, Town or Location: Richmond

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 13 S. Mulberry St.

10f. Zip Code: 23220

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Randolph Cox

18. Mother's Name (First, Middle, Maiden Surname): Rena Rainey Cox

19a. Informant's Name/Relationship (Type, Print): Mr. Michael Cox (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Marbur Drive Crownsville, Md. 21032

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oakwood Cemetery

Date: 12/21/03

20c. Location - City or Town, State: Richmond, Va.

21. Signature of Funeral Service Licensee: Joseph L. Russ per DVR

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple injuries

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) At scene

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): November 6, 2003

28b. Time of Injury: 11:11 A M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: passenger in motor vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Interstate

28f. Location (Street and Number or Rural Route Number, City or Town, State): I95 N @ 90.6 milemarker Havre de Grace, MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tasha L Zemmus M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): November 7, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tasha L Zemmus M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41058

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LOUISE BRYANT
2. Date of Death Month: 12 Day: 12 Year: 2003
3. Time of Death: 1327 PM
4a. Facility Name (If not institution, give street and number): BON Secours Hospital of Baltimore
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: 215-98-3403
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-7-25
9. Birthplace (State or Foreign Country): VA.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Md.
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1341 N. CAREY ST.
10f. Zip Code: 21217
10g. Citizen of What Country? U.S.A.

11. Maritat Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE
16b. Kind of Business/Industry: NURSING HOME

17. Father's Name (First, Middle, Last): JAMES BRADLEY
18. Mother's Name (First, Middle, Maiden Surname): MARY LOUISE UNKNOWN

19a. Informant's Name/Relationship (Type, Print): M. Idred Coles Neice
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1341 N. CAREY ST. BALTO. MD. 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Carmel cem.
Date: 12-22-03
20c. Location - City or Town, State: Dundalk md.

21. Signature of Funeral Service Licensee: Wesley Chavis
22. Name and Address of Facility: Wesley Chavis Jr. Funeral Home 2005 Eastern Ave. Balto. Md.

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure — Approximate Interval Between Onset and Death: 10 days

Due to (or as a consequence of):
b. Staphylococcus Pneumonia — 10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Severe Dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: H. Neal Reynolds MD
29c. License number: D27163
29d. Date signed (Month, Day, Year): 12/12/2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BON Secours Hospital, 2000 West Baltimore Street, Baltimore

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41059

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Evelyn V. Brown | December 17, 2003 | 1:10 A. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Future Care | Baltimore | Baltimore County |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-03-1451 | 1☐ M 2☒ F | 95 Yrs. | | | April 20, 1908 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Catonsville | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2106 Chantilla Rd | 21228 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 yr's | | Home maker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Unknown Powell | UNKNOWN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Carl Gold - Attorney | 402 W. Pennsylvannia Ave. Towson, MD 21204 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Meadowridge | 12/20/03 | Dorsey, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Paul L Hartsock Jr | Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: Sudden

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☑ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D40491 | 12/18/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Syed M.A. Riaz 800 North Haammonds Ferry Rd Catonsville MD 21090

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41060

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Clare Vanden Broek
2. Date of Death (Month, Day, Year): December 16, 2003
3. Time of Death: 9:15 PM M
4a. Facility Name (If not institution, give street and number): Manor Care Ruxton
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 485-05-5807
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 17, 1920
9. Birthplace (State or Foreign Country): Iowa

Usual Residence of Decedent

10a. State: PA
10b. County: Chester
10c. City, Town or Location: Exton
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 107 Bridle Lane
10f. Zip Code: 19341
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civil Engineer
16b. Kind of Business/Industry: Raytheon Corp.

17. Father's Name (First, Middle, Last): Martin Vanden Broek
18. Mother's Name (First, Middle, Maiden Surname): Ida Kaarhus

19a. Informant's Name/Relationship (Type, Print): Martin Vanden Broek / son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Old Wilson Bridge Rd. Suite 100; Worthington, OH 43085

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Phila Memorial Park
Date: 12/22/03
20c. Location - City or Town, State: Frazer, PA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, 1050 York Road, Towson, MD 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute CVA — Due to (or as a consequence of):
b. ATHEROSCLEROSIS — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. — Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death: weeks.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Acute Renal Failure.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D-12849
29d. Date signed (Month, Day, Year): 12-17-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.H. GHALADI. MD 7600 OSLER Dr. Towson Md 21204

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: [signature]

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #26 PER VERB G826 12/30/03 JH

# Certificate of Death

Reg. No. 2003 41061

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Emma Mae Brown | 12 | 13 | 03 | 12AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 30 Stockmills Rd. | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 248-62-5326 | 1☐M 2☒F | 62 Yrs. | | | 2-28-41 | S.Carolina |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2221 N. Pulaski St. | 21217 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes ☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Black & Decker US INC | Distribution Center |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Goodwin | Jeannette Littlejohn |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Robert Brown Husband | 2221 N. Pulaski St, Baltimore, Md. 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Druid Ridge Cem, | 12-20-03 | Baltimore, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Lloyd M. Esteb | Esteb Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Refractory CHF | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Post. Non Healing Diabetic Ulcer & Sepsis. | |
| | c. Due to (or as a consequence of): Angina | |
| | d. Due to (or as a consequence of): IDDM | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No N/A |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☒Other (Specify) DAUGHTER's RESIDENCE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | — | M | 1☐Yes 2☐No | — |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| — | — |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Dinu Patel MD | D 28530 | 12.18.03. |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINU PATEL MD 13 Walker Ave #202 Pikesville MD 21208

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | Lloyd M. Esteb |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41062

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: CLINTON SHEFFIE BRATTON
2. Date of Death Month Day Year: December 15, 2003
3. Time of Death: 1:15 AM
4a Facility Name *(If not institution, give street end number)*: 118 Maulsby Avenue
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 213-44-9573
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthdey)*: 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: Sept. 19, 1945
9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street end Number: 118 Maulsby Avenue
10f. Zip Code: 21014
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Edcetion *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Horse Trainer
16b. Kind of Business/Industry: Equestrian

17. Father's Neme *(First, Middle, Last)*: Raby James Bratton
18. Mother's Name *(First, Middle, Maiden Surname)*: Elsie Stella Smith

19a. Informant's Name/Relationship *(Type, Print)*: Virginia Bratton / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 118 Maulsby Ave., Bel Air, MD 21014

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gardens
Date: 12-20-03
20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Kathy A. Keefe
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Bel Air, Maryland 21014

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Lung Cancer — 5 months
Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b. Due to (or as e consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Menner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Phyeicien:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D45390
29d. Date signed *(Month, Day, Year)*: December 17th, 2003

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): MYO MIN (M.D.) 602 South Atwood Road # 200, Bel Air, MD 21014

**State Registrar**

31. Dete filed *(Month, Day, Year)*: DEC 19 2003
32. Registrer's Signature:

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hygiene.
**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires thet the death certificete be executed within 24 hours efter death.
To the **Funeral Director:** After this certificete has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 778 PER FH G826 12/24/03 JH

# Certificate of Death

Reg. No. 2003 41063

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Martha Chambers
2. Date of Death: Month DEC Day 11 Year 2003
3. Time of Death: 2:09 AM
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-22-4568
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 90 Yrs. ~~Mos.~~ ~~Days~~ If Under 1 Year: Months Days; If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): AUG 28, 1913
9. Birthplace (State or Foreign Country): ~~York~~ Virginia

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 5417 Hillen Rd.
10f. Zip Code: 21239
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): John Walker
18. Mother's Name (First, Middle, Maiden Surname): Rebecca

19a. Informant's Name/Relationship (Type, Print): Mr. Bernard Gibson (nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5417 Hillen Rd. Balto. Md. 21239

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest
Date: 12/22/2003
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Ventricular Fibrillation — Approximate Interval Between Onset and Death: 6 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Aortic Brain Injury — 6 hours
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypotension

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Olalekan Peter Olufemi, M.D.
29c. License number: P16701
29d. Date signed (Month, Day, Year): DEC 11, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): OLALEKAN PETER OLUFEMI SAINT AGNES HEALTHCARE 900 CATON AVENUE, BALTIMORE, MARYLAND 21229

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature:

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Chambers, Martha

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1/3/04 tas

Amend Item #6 per fh G827

# Certificate of Death

Reg. No. 2003 41064

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Darlene Kay Cheek | December 14, 2003 | 8:15 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2006 Beech Street | Bel Air | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-44-0580 | 1☐ M 2☒ F | 56 Yrs. | | | Nov. 26, 1947 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Bel Air | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2006 Beech Street | 21015 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Truck Driver | Medical Transportation |

| 17. Father's Neme (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Clinton Ray Bowman | Prema Clara Friend |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Larry A. Cheek / Husband | 2006 Beech St., Bel Air, Maryland 21015 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Bel Air Memorial Gardens | 12-17-03 | Bel Air, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | McComas Funeral Home, P.A. 50 W. Broadway St., Bel Air, Maryland 21014 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Non small cell lung cancer | 2y 6mo |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D0055065 | 12/16/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Martin Edelman 22 S Greene St., Baltimore, MS 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | [signature] |

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mantal Hygiena. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law raquiras that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificata has bean signed by the attanding physician and completely filled in by tha funeral director, paga 2 should be datached for usa as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41065

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| MIRIAM LOUISE COALE | December 15 2003 | 10:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Franklin square Hospital | Rosedale | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-24-9640 | 1☐ M 2☒ F | 77 Yrs. | | | Sept. 28, 1926 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Fallston | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2218 Watervale Road | 21047 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Oscar S. Beale | Mildred (unk) Harkins |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Edward Coale - Husband | 2218 Watervale Road, Fallston, Maryland 21047 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Fallston U.M. Cem. | 12/22/03 | Fallston, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Adeno carcinoma, unknown primary | 2 Minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M. Purtell | 014714 | 12/15/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL PURTELL 602 S. ATWOOD Rd SUITE 200 Bel Air Md. 21014

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41066

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Doris E. Carter | Dec. 16, 2003 | 3:30 M p |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1417 Reynolds Street | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-22-9151 | 1☐ M 2☒ F | 76 Yrs. | | | Aug. 15, 1927 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore City | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1417 Reynolds Street | 21230 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | 0 | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George W. Taylor | Edna May Reiter |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| William F. Carter, Sr. | 1417 Reynolds Street, Baltimore MD 21230 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Glen Haven Cem., | Dec. 20, 2003 | Glen Burnie, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Victor P. Doda, Jr. | Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. metastatic rectal cancer | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) — 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D40854 | 12/16/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Rusberg 301 St Paul Pl Baltimore 21202

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-I show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41067

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| ROSE | CROUSE | DECEMBER 18, 2003 | 3:50 A.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GILCHRIST CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-10-4461 | 1☐ M 2☒ F | 83 Yrs. | | | 11/24/1920 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | CARNEY | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2327 HARFORD HILLS ROAD | 21234 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10TH GRADE | | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOSEPH SIEMEK | VERONICA YUREK |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| GAIL CROUSE DAUGHTER | 2327 HARFORD HILLS ROAD CARNEY, MD 21234 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | METRO CREMATORY, INC. | 12/19/2003 | CATONSVILLE, MD |

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Breast Cancer | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ W. A. Riley MD | D35205 | December 18, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley GSMC 6701 N. Charles St. Balto. Md 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Crouse, Rose 12/18/03 3:50AM

10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41068

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): **Charles Branch Clark, Sr.**
2. Date of Death (Month, Day, Year): December 11, 2003
3. Time of Death: 5:20 a.m. M

4a. Facility Name (If not institution, give street and number): Gilchrist Hospice Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 214.32.0966
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 5, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3776 Church Road
10f. Zip Code: 21043
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1942 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Political Science Administration / Historian
16b. Kind of Business/Industry: Universtiy

17. Father's Name (First, Middle, Last): Louis Thomas Clark
18. Mother's Name (First, Middle, Maiden Surname): Desiree Branch

19a. Informant's Name/Relationship (Type, Print): Ms. Becky Jane Clark Spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3776 Church Road Ellicott City, Maryland 21043

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Cemetery
Date: 12/15/2003
20c. Location - City or Town, State: Ellicott City, MD

21. Signature of Funeral Service Licensee: Melody Fisher MD323
22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Dementia — Approximate Interval Between Onset and Death: 4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: C. Charlson
29c. License number: D58303
29d. Date signed (Month, Day, Year): December 11, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Aaron Charles MD 1601 North Charles St Balto, MD 21304

**State Registrar**

31. Date filed (Month, Day, Yeer): DEC 19 2003
32. Registrar's Signature: Brenda L. Speed

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41069

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| SYLVESTER | | DINKENS | December 10 2003 | 0956 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHNS HOPKINS BAYVIEW MEDICAL CENTER | BALTIMORE | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-56-5702 | 1 ☒ M 2 ☐ F | 52 Yrs. | | | 1-20-51 | Md. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | BALTO. | | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 111 EASTERN Blvd. | 21221 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 16 YRS | | LABORER | WAREHOUSING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lee DINKENS | BERTHA CRAWFORD |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Nicole Hartley Daughter | 111 Eastern Blvd. |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Mt. Carmel Cem. | 12.20.03 | DUNDALK Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Wesley Chavis | Wesley Chavis Jr. Funeral Home 2067 Eastern Ave. Balto. 21231 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Septic Shock | 2 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Pneumonia | 4 days |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

Urinary Tract Infection

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature], Medical Doctor | RES-000 | December 10, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JORDAN PRUTKIN, MD, JHBMC, 4940 Eastern Avenue, Baltimore, Maryland 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item#1perPHYG826 12/24/03 EW

# State of Maryland / Department of Health and Mental Hygiene
# Certificate of Death

Reg. No. 2003 41070

PATIENT KNOWN AS: RICHARD E. BROOKS

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ~~RICHARD EDWARD~~ Richard Edward Brooks
2. Date of Death (Month, Day, Year): DECEMBER 15 2003
3. Time of Death: 4:15 PM
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 423-42-5122
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-11-1934
9. Birthplace (State or Foreign Country): FL

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4011 RIDGEWOOD AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+): 4 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
16b. Kind of Business/Industry: TRANSPORTATION
17. Father's Name (First, Middle, Last): PROFESSOR BROOKS
18. Mother's Name (First, Middle, Maiden Surname): NANCY SHORTS
19a. Informant's Name/Relationship (Type, Print): LENA BROOKS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4011 RIDGEWOOD AVE., BALTO. MD 21215
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING PARK
Date: 12-22-03
20c. Location - City or Town, State: RANDALLSTOWN, MD
21. Signature of Funeral Service Licensee: ▶ Vaugh C Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO.-NATL PIKE, BALTO. MD 21229

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 1 HOUR

Immediate Cause (Final disease or condition resulting in death):
a. CARDIAC ARRHYTHMIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.
SLEEP APNEA

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ William P Jaques, MD
29c. License number: D57429
29d. Date signed (Month, Day, Year): DECEMBER 16, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM P JAQUES, MD SINAI HOSPITAL OF BALTIMORE

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: Jennifer B Sparks

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41071

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Samuel Louis Easter
2. Date of Death Month / Day / Year: December 17, 2003
3. Time of Death: 1:40 A
4a. Facility Name *(If not institution, give street and number)*: Stella Maris at Mercy Hosp.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 224-40-8165
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 19, 1933
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 923 E. 41st St.
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dept. of Water Supply
16b. Kind of Business/Industry: Baltimore City

17. Father's Name *(First, Middle, Last)*: James Easter
18. Mother's Name *(First, Middle, Maiden Surname)*: Pearl Gibbons

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Florence Easter (wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 923 E. 41st St. Balto. Md. 21218

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Memorial Park — Date: 12/20/2003
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home, 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. lung cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. / Due to (or as a consequence of): / c. / Due to (or as a consequence of): / d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other *(Specify)* hospice
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D40854
29d. Date signed *(Month, Day, Year)*: 12/17/2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Rosebery MD 301 St Paul Pl Baltimore 21202

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 19 2003
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Easter, Samuel L.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41072

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Sylvia Mary Eccleshall
2. Date of Death Month Day Year: December 15, 2003
3. Time of Death: 2:15 PM
4a. Facility Name *(If not institution, give street and number)*: 1513 Charter Oak Drive
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 212-62-8695
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 29, 1928
9. Birthplace *(State or Foreign Country)*: England

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1513 Charter Oak Avenue
10f. Zip Code: 21014
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Private Education

17. Father's Name *(First, Middle, Last)*: Richard Alfred Plant
18. Mother's Name *(First, Middle, Maiden Surname)*: Olive Mary Davenport

19a. Informant's Name/Relationship *(Type, Print)*: Donald Eccleshall - Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1513 Charter Oak Avenue, Bel Air, Maryland 21014

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp.
Date: 12/17/03
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrest
Due to (or as a consequence of):
b. hyper tension
Due to (or as a consequence of):
c. insulin resistance
Due to (or as a consequence of):
d. Alzheimer's - type dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephanie Linder MD
29c. License number: D0043909
29d. Date signed *(Month, Day, Year)*: December 16, 2003

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Stephanie Linder 902 Averill Rd Joppa, MD 21085

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 19 2003
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41073

Physician /Medical Examiner

Funeral Director

| | | | |
|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): KATHERINE ELLEN FOERTSCHBECK | 2. Date of Death (Month Day Year): DECEMBER 15 2003 | 3. Time of Death: 11.50a M | |
| 4a. Facility Name (If not institution, give street and number): FREDERICK MEMORIAL | 4b. City, Town, or Location of Death: FREDERICK | 4c. County of Death: FREDERICK | |
| 5. Social Security Number: 215-01-1331 | 6. Sex: 1☐M 2☒F | 7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min. |
| 8. Date of Birth (Month, Day, Year): JUNE 7, 1915 | 9. Birthplace (State or Foreign Country): MARYLAND | | |

Usual Residence of Decedent

| | | | |
|---|---|---|---|
| 10a. State: MD. | 10b. County: CARROLL | 10c. City, Town or Location: MT. AIRY | 10d. Inside City Limits: 1☐Yes 2☒No |
| 10e. Street and Number: 713 MIDWAY AVENUE | 10f. Zip Code: 21771 | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify: | 14. Race - American Indian, Black, White, etc. Specify: WHITE |
| 15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+): | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE | 16b. Kind of Business/Industry: DOMESTIC | |
| 17. Father's Name (First, Middle, Last): JOHN BETCH | 18. Mother's Name (First, Middle, Maiden Surname): ANNA E. SIMMONT | | |
| 19a. Informant's Name/Relationship (Type, Print): JOHN FOERTSCHBECK, III/SON | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7130 JOHN PICKETT ROAD, WOODBINE, MD. 21797 | | |
| 20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place): SACRED HEART OF JESUS | Date: 12/18 | 20c. Location - City or Town, State: BALTIMORE, MARYLAND |
| 21. Signature of Funeral Service Licensee: [signature] | 22. Name and Address of Facility: LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD. 21224 | | |

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE RENAL FAILURE — Approximate Interval Between Onset and Death: 5 DAYS

Due to (or as a consequence of):
b. PNEUMONIA — 10 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS TYPE 2

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) — Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D-31912

29d. Date signed (Month, Day, Year): 12/15/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JULIO MENDOZA, MD - 1564 OPOSSUMTOWN PIKE, FREDERICK, MD 21702

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

10

State Registrar

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41074

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Gertrude D. Ford
2. Date of Death Month / Day / Year: 12 / 16 / 2003
3. Time of Death: 1115 pm
4a. Facility Name *(If not institution, give street and number)*: Long View Nursing Home
4b. City, Town, or Location of Death: Manchester
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 217-18-6018
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 20 1921
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Carroll
10c. City, Town or Location: Manchester
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3332 Main Street
10f. Zip Code: 21102
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Office Manager
16b. Kind of Business/Industry: Gilman School

17. Father's Name *(First, Middle, Last)*: Michael Joseph Devlin
18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Margaret Connor

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Martin Ford/ Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8406 D Charles Valley Ct. Towson, Md. 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Dulaney Valley Mem Gdns
Date: 12-19-03
20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. [illegible] Dementia
Due to (or as e consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☐ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier ▶ MD
29c. License number: D35165
29d. Date signed *(Month, Dey, Year)*: 12/17/03
30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Steven Shaffer 2111 Hanover Pike Hampstead 21074

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 19 2003
32. Registrer's Signature ▶

DHMH 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41075

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| KIMBERLY | ANN | FORTUNE | DECEMBER | 4 | 2003 | 6:59 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HARBOR HOSPITAL | BALTIMORE | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 215-86-7276 | 1☐M 2☒F | 34 Yrs. | | | | | 5-27-69 | Md. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | | BALTO. | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4118 Westbay Ct. | 21225 | U. S. A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | NURSE | PRIVATE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JAMES Fortune | Paulette Love |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Paulette Love Mother | 4118 Westbay Ct. BALTO. Md. 21225 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | BAYVIEW | 12-16-03 | DUNDALK Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Wesley Chaffe | Wesley Chaffe, Sr. FUNERAL HOME 2007 EASTERN AVE. BALTO. Md. 21231 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. DISSEMINATED INTRAVASCULAR COAGULATION | 12 hrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. SEPTAECEMIA Due to (or as a consequence of): | 1 day |
| | c. ACUTE RENAL FAILURE Due to (or as a consequence of): | 1 day |
| | d. ADULT RESPIRATORY DISTRESS SYNDROME | 12 hrs. |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☒Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HEPATITIS - C

CIRRHOSIS

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☐Yes 2☒No |

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one) — Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) — 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Nirish Sh IMO PGY-2 | P-16775 | DECEMBER 4 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRISH SHAH, MD HARBOR HOSPITAL 3001, S. HANOVER ST. BALTIMORE, MD - 21225

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ P. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41076

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| SYLVIA GRACE-PAUL | 12-14-2003 | 1:45 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| MANOR CARE RUXTON | TOWSON | BALTO. |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-28-5721 | 1☐ M 2☒ F | 13 Yrs. | | | 10-02-1930 | DC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | GWYNN OAK | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3400 REDMAN ROAD | 21207 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 TH GRADE | 6 YRS | SOCIAL WORKER | STATE OF MD. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CHARLES CALDWELL | EDITH BROWN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JAMES PAUL | 3400 REDMAN RD. BALTO. MD. 21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | LOUDON PARK | 12-19-03 | BALTO. MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Wayne C | VAUGHN C. GREENE FUNERAL SER. 5151 BALTO-NATL. PIKE, BALTO. MD 21229 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D0056725 | 12/17/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RASHA MORAD, MD 7505 OSLER DRIVE TOWSON, MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41077

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Sarah V. Greenwood
2. Date of Death (Month, Day, Year): DECEMBER 12 2003
3. Time of Death: 20:32 M
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 230-16-0682
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 25, 1922
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2444 Nevada St.
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Educator
16b. Kind of Business/Industry: Public School

17. Father's Name (First, Middle, Last): Paul Wyatt
18. Mother's Name (First, Middle, Maiden Surname): Bessie Stewart

19a. Informant's Name/Relationship (Type, Print): Mrs. Vernetta Greenwood (daughter-in-law)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2444 Nevada St. Balto. Md. 21230

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount
Date: 12/18/2003
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: 18 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b. HYPERTENSION — 15 YEARS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: REAZ SIDDIQUI, MD
29c. License number: AT 2438946-C10
29d. Date signed (Month, Day, Year): DECEMBER 12, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): REAZ SIDDIQUI 201 E UNIVERSITY PARKWAY, BALTIMORE, MARYLAND 21218

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41078

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Woodrow Grubbs, Sr.
2. Date of Death (Month, Day, Year): December 17, 2003
3. Time of Death: 6:45 A M
4a. Facility Name (If not institution, give street and number): Quail Run Assisted Living
4b. City, Town, or Location of Death: Perry Hall
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 539-09-0879
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 25, 1917
9. Birthplace (State or Foreign Country): Washington

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9406 Pinedale Circle
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civil Service
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Corbin L. Grubbs
18. Mother's Name (First, Middle, Maiden Surname): Audrey L. Lively

19a. Informant's Name/Relationship (Type, Print): Dorothy D. Ryan (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 401 Ellery Court, Edgewater, NJ 07020

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 12/20/2003
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lymphoma

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Coronary Artery Disease
c. Due to (or as a consequence of): Hypertension
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Assisted Living

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D27185
29d. Date signed (Month, Day, Year): 12/19/03
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 2 Market Place Dundalk MD 21222

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 17 Rev 1/2001

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41079

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Frank Joseph Gross | December 17, 2003 | 2:11 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 808 Wampler Road | Middle River | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-01-5203 | 1☒M 2☐F | 87 Yrs. | | | March 9, 1916 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Middle River | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 808 Wampler Road | 21220 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 45-46 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | Machine Operator | Aero-Space |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Stanislau Grus | Annie Palusiak |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia Dickson (Daughter) | 8504 Rhuddlan Road, Nottingham, Maryland 21236 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Holly Hill Mem. Gar. | Dec. 19, 2003 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive Heart Failure | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] Physician | D39758 | 12-18-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kevin Schenkel MD 9101 Franklin SQ Dr, Suite 321, Balto MD 21237

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41080

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Landon Godsey Jr.

2. Date of Death Month Day Year: DECEMBER 17, 2003

3. Time of Death: 11:51 AM

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BOULEVARD. BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE, MARYLAND

4c. County of Death:

**Funeral Director**

5. Social Security Number: 219-18-6528

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 3, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1639 Heathfield Rd.

10f. Zip Code: 21239

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tractor Operator

16b. Kind of Business/Industry: Steel

17. Father's Name (First, Middle, Last): Landon Godsey Sr.

18. Mother's Name (First, Middle, Maiden Surname): Esther Arvin

19a. Informant's Name/Relationship (Type, Print): Elsie Godsey wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1639 Heathfield Rd. Balto. Md. 21239

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville Vet Cem.

Date: Dec23 2003

20c. Location - City or Town, State: Crownsville Md.

21. Signature of Funeral Service Licensee: Carlton C. Douglas

22. Name and Address of Facility: Carlton C. Douglas Funeral Service P.A. 1701 McCulloh St. Balto. Md. 21217

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. METASTATIC BLADDER CANCER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE
URINARY TRACT INFECTION
ANASARCA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nilesh Patel MD.

29c. License number: RES 000

29d. Date signed (Month, Day, Year): DECEMBER 17th 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NILESH PATEL MD 5601 LOCH RAVEN BOULEVARD BALTIMORE MD 21239

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760**

LANDON GODSEY JR

10x1

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No.: 2003 41081

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Harold Harcum | 12 / 12 / 2003 | 545 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland 22 S Greene St | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-12-6420 | 1 ☒ M 2 ☐ F | 84 Yrs. | | | 07-21-1919 | VA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1 ☑ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1224 N. GILMORE ST. | 21217 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12TH GRADE | N/A | TRASH COLLECTOR | CITY OF BALTO. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| UNK | UNK |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| BARBARA SAVAGE | 3924 BARENA RD., BALTO. MD. 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | MT. ZION | 12-19-03 | BALTO. MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ David C [illegible] | VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 21229 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Chronic obstructive pulmonary disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☑ No | 1 ☐ Yes 2 ☐ No |

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ E Fontanilla MD | P17672 | 12/12/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
E FONTANILLA 22 S Greene St Baltimore MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ [illegible] B Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41082

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Charles Hardy
2. Date of Death (Month - Day - Year): 12 - 12 - 03
3. Time of Death: 1:15 am
4a. Facility Name (If not institution, give street and number): Mariner Catonsville
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-22-8230
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09-11-27
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 179 Winters Lane
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Driver
16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): Samuel Hardy
18. Mother's Name (First, Middle, Maiden Surname): Eva Webb

19a. Informant's Name/Relationship (Type, Print): Patricia Carter (Dghtr)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1203 Brigadoon Tr., Balto., MD 21207

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN — Date: 12.16.03
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C. Greene
22. Name and Address of Facility: Vaughn C. Greene Funeral Svc. 5151 Balto. Nat'l Pike, Balto. MD 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Squamous Cell Carcinoma of Esophagous | 6 months |
| Due to (or as a consequence of): b. | Chronic aspiration | 3 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Bonnie Cohen MD
29c. License number: 041797
29d. Date signed (Month, Day, Year): December 12, 2003

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print): Bonnie Cohen, MD 7141 Security Blv Baltimore MD 21244

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **Amend Item #1 per phy** G826 12/19/03 tas *Certificate of Death*

Reg. No. 2003 [illegible]

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Helen M Haddaway — Haddaway, Helen
2. Date of Death Month/Day/Year: 12/13/2003
3. Time of Death: 12:02 PM
4a. Facility Name (If not institution, give street and number): 2204 Sunset Drive North
4b. City, Town, or Location of Death: Eldersburg
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 212-09-4670
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 103 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 13 1900
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: Carroll
10c. City, Town or Location: Eldersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2204 Sunset Drive North
10f. Zip Code: 21784
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
16b. Kind of Business/Industry: Social Security Adm.

17. Father's Name (First, Middle, Last): William T. McQuay
18. Mother's Name (First, Middle, Maiden Surname): Addie C. Keithley

19a. Informant's Name/Relationship (Type, Print): Frances Ironmonger (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2012-D Rudy Serra Dr., Eldersburg, Md 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cem.
Date: 12-19-03
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Paige Haight Herbert
22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R.J. Walsh
29c. License number: D 35662
29d. Date signed (Month, Day, Year): 12/15/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Walsh 4660 Wilkens Ave, Baltimore, MD 21229

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41084

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EDMOND HOPKINS
2. Date of Death Month Day Year: December 17, 2003
3. Time of Death: 10:55 PM
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 231-14-1032
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 16, 1923
9. Birthplace (State or Foreign Country): Virginia

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 19 N. Monastery Ave.
10f. Zip Code: 21229
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4or 5+): 6
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Fork Lift Driver
16b. Kind of Business/Industry: Bethlehem Steel Co.

17. Father's Name (First, Middle, Last): John Hopkins
18. Mother's Name (First, Middle, Maiden Surname): Mildred Butler

19a. Informant's Name/Relationship (Type, Print): Mr. Edmond Hopkins Jr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19 N. Monastery Ave. Balto. Md. 21229

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest
Date: 1/2/2004
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. DILATED CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
c. HYPERTENSIVE CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Rosita R. Cruz M.D.
29c. License number: D0030355
29d. Date signed (Month, Day, Year): December 17, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROSITA R. CRUZ M.D. BON SECOURS HOSPITAL

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41085

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| MARIAN | ELIZABETH | HOWARD | DECEMBER 17, 2003 | 14:10 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2508 HOLLY SPRINGS ROAD | ELLICOTT CITY | HOWARD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 405-32-9971 | 1☐ M 2☒ F | 76 Yrs. | | | 9/11/1927 | Kentucky |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | HOWARD | ELLICOTT CITY | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2508 HOLLY SPRINGS COURT | 31043 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes ☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | POSTAL CLERK | US POSTAL SERVICE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| PHILLIP HARRIS | GRACE DAVIS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ELTON HOWARD | 2508 HOLLY SPRINGS COURT, ELLICOTT CITY MD 31043 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | ROSE HILL CEMETERY | 12/30/2003 | WHITTIER, CA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| KELLY GREGORY FINK #MO1148 | FINK FUNERAL HOME, PA 426 CRAIN HWY., S, GLEN BURNIE, MD 21061 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pancreatic Cancer | 6 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D50778 | December 19, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Price 11055 Little Patuxent Pkwy Columbia MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

STEPHEN M.HARNEY
03-7951
DAP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

UNPEND ITEM 23a&27 PER ME G827 1/15/04 JH

State of Maryland, Department of Health and Mental Hygiene

G826 12/19/03 tas

# Certificate of Death

1- For State Registrar **Amend Item #1 per me**

Reg. No. 2003 41086

2827

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ~~Stephen John Harney~~ **Stephen M. Harney** | DECEMBER 10, 2003 | 10:20 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1305 C CLOVER VALLEY WAY | EDGEWOOD | HARFORD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-64-8551 | 1☒M 2☐F | 51 Yrs. | | | Jan 30, 1952 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Edgewood | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1305 C Clover Valley Way | 21040 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) 1 | Postal Clerk | U.S. Postal Service |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Stephen Mioduszewski | Mabel Margaret Hanson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ms. Susan Mioduszewski/Sister | 8 Sandstone Court, Baltimore, MD 21236 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | Dec 18 2003 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ M60986 | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? 1☒Yes 2☐No | 24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No |
|---|---|

| 25. Was case referred to medical examiner? 1☒Yes 2☐No | 26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE |
|---|---|

| 27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M.D | OCME | DECEMBER 11, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LING LI, M.D 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

OK Fax

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41087

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| James Thomas Hayes | December 15, 2003 | 10:07 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Gilchrist Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-09-5960 | 1☒ M 2☐ F | 85 Yrs. | | | March 8, 1918 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | n/a | Baltimore | 1☐ Yes 2☐ No X |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5508 Morello Road | 21214 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | n/a | Mechanic | D.O.T/ Baltimore City Police Department |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Thomas Hayes | Georgia Thamagos |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sophie T. Hayes-wife | 5508 Morello Rd., Baltimore, MD 21214 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Greek Orthodox Cemetery | 12/19/03 | Woodlawn, MD |

21. Signature of Funeral Service Licensee: William G. Dau

22. Name and Address of Facility: Leonard J. Ruck, Inc. Funeral Home, 5305 Harford rd., Baltimore, MD 21214

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Dementia | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) (HOSPICE

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D 58303 | December 16 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Aaron J Charles MD 6601 N. Charles St Baltimore MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**
**Division of Vital Records, P.O. Box 68760,**

Monday, December 15th 2003 @ 1007 PM

Hayes, James 12/15/03 @ 2207

104

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 [illegible]

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ALLAN C. HILL | DECEMBER 14 2003 | 5.15A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-48-2072 | 1[X] M 2[ ] F | 61 Yrs. | | | 4/12/42 | MD. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | na | BALTIMORE | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5908 BELL GROVE RD. | 21225 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | SKILL WORKER | ANNA ARUNDEL CO. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JAMES WHITE | MARY B. STURDIVANT |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ANGELA HUDSON (SISTER) | 453 DARTON CT. GLEN BURNIE, MD. 21061 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | CEDAR HILL CEM. | 12/20/03 | BROOKLYN, MD. AA CO. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ C.A.ESTEP | ESTEP BROS. FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA

Due to (or as a consequence of):
b. Seizure Disorder

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hypertension

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown

23c. If yes, outcome of pregnancy 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed? 1[ ] Yes 2[X] No

24b. Were autopsy findings available prior to completion of cause of death? 1[ ] Yes 2[X] No

25. Was case referred to medical examiner? 1[ ] Yes 2[X] No

26. Place of Death (Check only one)
Hospital: 1[X] Inpatient 2[ ] ER/Outpatient 3[ ] DOA
Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1[ ] Yes 2[ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D45149 | December 14 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONAIYATO 301 Hospital Drive Glen Burnie MD 21061

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ [signature] |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Hill, Allan

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland Department of Health and Mental Hygiene

1- For State Registrar Amend Item #8 per fh G827 — *Certificate of Death* — Reg. No. 2003 41089

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| ELMER P. JENNINGS | 12 / 16 / 2003 | 10:50 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-03-2332 | 1 ☒ M 2 ☐ F | 89 Yrs. | | | 11-9-14 ~~11-19-1914~~ | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1 ☒ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3930 DUVALL AVE. | 21216 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No *Specify:* | *Specify:* BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12TH GRADE | N/A | ENGINEER | DEPT - OF EDUCATION |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOHN JENNINGS | AMANDA COLEMAN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MONTEE JENNINGS | 3930 DUVALL AVE., BALTO. MD 21216 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | GARRISON FOREST | 12-23-03 | OWINGS MILLS, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | VAUGHN C. GREENE FUNERAL SERVICE 5101 BALTO. NATL. PIKE. BALTO. MD 21229 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | 48 hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last | Due to (or as a consequence of): b. Pneumonia | 48 hours |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, hypertension, decubitus ulcers, throat and prostate cancer

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] Medical doctor | RES 000 | December 16, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VISHNUPRIYA, KITTANE 2401 West Belvedere Avenue Baltimore Maryland 21215

**State Registrar**

| 31. Date Filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ [signature] |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Elmer P Jennings

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41090

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY HELEN JONES
2. Date of Death Month Day Year: 12-10-2003
3. Time of Death: 8:00 AM
4a. Facility Name (If not institution, give street and number): 511 N. CUMBERLAND ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 231-30-2827
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 06-01-1927
9. Birthplace (State or Foreign Country): VA

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 511 N. CUMBERLAND ST
10f. Zip Code: 21217
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 TH GRADE | College (1-4or 5+): 2 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERICAL
16b. Kind of Business/Industry: SOC. SEC. ADMIN.

17. Father's Name (First, Middle, Last): NATHAN BANKS
18. Mother's Name (First, Middle, Maiden Surname): AMANDA BURRELL

19a. Informant's Name/Relationship (Type, Print): SHIRLEY ATKINS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 611, WESTPOINT, VA 23181

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD NATL
Date: 12-15-03
20c. Location - City or Town, State: LAUREL MD

21. Signature of Funeral Service Licensee: Vaughn C Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 3151 BALTO. NATL PIKE, BALTO. MD 21229

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death):
a. Cancer of the Lung — Approximate Interval Between Onset and Death: 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Cancer of the Bluestar Ridge — 1 year
c. Due to (or as a consequence of): Hypertension — 20 years
d. Due to (or as a consequence of): Ischemic Heart Disease — 20 years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Obesity

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Larry S. Penny MD
29c. License number: R21031
29d. Date signed (Month, Day, Year): 12-12-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Larry S. Penny MD 2116 Maryland Ave Balto. md 21218

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
Registrar's Signature: James B Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MARY JONES

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41091

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Charles | Johnson | | December 10 2003 | 23:25 |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Mercy Medical Center | Baltimore | City |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-52-3754 | 1 X M 2 ☐ F | 52 Yrs. | | | 04-25-1951 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2402 SEABURY RD. # B | 21225 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12TH GRADE | N/A | LINEN SERVICES | HOSPITAL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CHARLES JOHNSON | JEAN CANN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CHRISTINE CANN | 1322 FULTON AVE., BALTO. MD 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | CEDAR HILL | 12-16-03 | BALTO. MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Vaughn C. Greene | VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Ischemic Bowel | 24 hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Stroke
Pancreatitis
Human Immunodeficiency Virus Infection

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Karen A. Karick, MD | D40744 | December 10, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
K. A. Karick, MD Mercy Medical Center 301 St. Paul Place Baltimore MD 21202

**State Registrar**

31. Date filed (Month, Day, Year) DEC 19 2003 ▶ Registrar's Signature: Donna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **Amend Item #20b per fh** G626 12/19/03 tas *Certificate of Death* Reg. No. 2003 41092

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Barthelmy | Joseph | | 12 | 16 | 2003 | 15:55 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore, City | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 580-12-7483 | 1 ☒ M 2 ☐ F | 55 Yrs. | | | | | 2/14/1948 | West Indies |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| St. Croix | | Frederiksted | 1 ☐ Yes ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3-A White Lady | 00840 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes ☒ No *Specify:* | *Specify:* Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Self Employed | Plumber |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lincoln Sevrier | Rose Joseph |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Marguerite Joseph | 3-A White Lady, Frederiksted, St. Croix 00840 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Kingshill Cemetery | 12-30-03 | St. Croix Christiansted, |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Kelly Gregory Fink MO1148 | FINK FUNERAL HOME, PA 426 CRAIN HWY., S, GLEN BURNIE, MD 21061 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — 24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HIV

primary effusion lymphoma

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Bhatia MD | RES-000 | 12-16-2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rinky Bhatia Johns Hopkins Hospital 600 N. Wolfe St. Baltimore, MD 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41093

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| OCTAVIA | KONIGKREMER | DEC. 18, 2003 | 11 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3703 FOSTER AVENUE | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-09-0965 | 1☐ M 2☒ F | 87 Yrs. | | | AUG. 7, 1916 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | N/A | BALTIMORE | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3703 FOSTER AVENUE | 21224 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-45 | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | CLERK | STANDARD OIL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| FREDERICK W. KONIGKREMER | KATIE E. BOWERS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| OCTAVIA AMY MILLER/NIECE | 5008 STUDLEY ROAD, MECHANICSVILLE, VA. 23116 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | OAK LAWN CEMETERY | 12/22/03 | BALTIMORE, MARYLAND |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: LILLY & ZEILER INC. FUNERAL HOME, 700 S. CONKLING STREET, BALTO., MD. 21224

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Cardio Vascular Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Macular Degeneration

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ R.T. Liberto, MD. | D21464 | 12-19-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert L Berto, MD. 3508 Bank St Balto, Md 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ [signature] |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene 2003 41094

1- For State Registrar

# Certificate of Death

Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edmund William Kowalski

2. Date of Death (Month, Day, Year): December 18, 2003

3. Time of Death: 7:45 P M

4a. Facility Name (If not institution, give street and number): Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 171-01-3802

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 11, 1915

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Street

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3708 Grier Nursery Road

10f. Zip Code: 21154

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Beth. Steel Shipyard

17. Father's Name (First, Middle, Last): Frank Kowalski

18. Mother's Name (First, Middle, Maiden Surname): Rose Stefanik

19a. Informant's Name/Relationship (Type, Print): Mrs. Ruth Biedermann (dghtr)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3865 Norrisville Road, Jarrettsville, MD 21084

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith

Date: 12/22/2003

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Bruce A. Miller

22. Name and Address of Facility: Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation, Congestive Heart Failure, renal failure, Urinary tract infection

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T. Timothy Riley MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): December 19, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto, Md 21208

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Kowalski, Edmund 12/18/03 7:45 PM

6

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41095

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Frances M. Carr Karwacki
2. Date of Death Month Day Year: December 18, 2003
3. Time of Death: 12:28 AM
4a. Facility Name (If not institution, give street and number): GBMC
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore Co.

**Funeral Director**

5. Social Security Number: 218-07-0822
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 96 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 29, 1907
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3625 Echodale Avenue
10f. Zip Code: 21214
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yrs. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Beautician
16b. Kind of Business/Industry: Self Employeed

17. Father's Name (First, Middle, Last): Frank Wernick
18. Mother's Name (First, Middle, Maiden Surname): Mary Sliwinski

19a. Informant's Name/Relationship (Type, Print): Mrs. Valerie Kline / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3625 Echodale Avenue Baltimore, MD 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cemetery
Date: 12/22/2003
20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Michael E. Canapp
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — Due to (or as a consequence of): — 12/17/03

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d. —

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease
Congestive Heart Failure
Anemia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: 053283
29d. Date signed (Month, Day, Year): 12/18/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Tsilos 1147 South Hanover Street Baltimore MD 21230

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: Janice B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41096

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| John Edward Koch | December 17 2003 | 0139 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Upper Chesapeake Medical Center | Bel Air | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-14-4954 | ☒ M ☐ F | 80 Yrs. | | | May 26, 1923 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Joppa | ☐ Yes ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1508 Singer Road | 21085 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced | ☐ Yes ☒ No If Yes, Give Year or Dates: | ☐ Yes ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Litographer | Can Manufacturer |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Henry Koch | Mildred M. Bell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mildred V. Koch / Wife | 1508 Singer Road, Joppa, MD 21085 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) | Highview Memorial Grdns | 12-20-03 | Fallston, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Billy McComas Reuter | McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PNEUMONIA | 3 DAYS |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | |
| | Due to (or as a consequence of): | |
| | c. CONGESTIVE HEART FAILURE | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| ☐ Yes ☒ No ☐ Unknown | ☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy ☐ Pregnant at time of death ☐ Other (specify) ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| ☐ Yes ☒ No | ☐ Yes ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| ☐ Yes ☒ No | Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined | | M | ☐ Yes ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Andrew Nowakowski MD | D08096 | DECEMBER 17, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANDREW NOWAKOWSKI MD 125 N. MAIN ST BEL AIR, MD 21014

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12/17/03 0139

Koch, John Edward #042181

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar: Amend Item#20bperFHG827 1/8/04 EW AMEND ITEM #12 PER FH G828 2.12/04 JH

Reg. No. 2003 41097

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Thomas Addison Langley | December 18, 2003 | 8:45 am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 7 Woodland Avenue | Middle River | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-18-5705 | 1 X M 2 ☐ F | 80 Yrs. | | | 8/31/1923 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Middle River | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7 Woodland Avenue | 21220 | U. S. A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No 1943 ~~1957~~ 1963 | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Diesel Mechanic | Heavy Truck |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Bactor Langley | Helen Wilson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Donna Langley (Daughter) | 7 Woodland Avenue Middle River, Maryland 21220 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Holly Hill | 12 ~~11~~/22 2003 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Michael C. Jeffries, Sr. | Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Chronic Obstructive Pulmonary Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Hypertension — Years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Allen Reilly MD | D 54749 | 12/18/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Allen Reilly MD 4805 Benson Avenue Baltimore, Maryland 21227

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41098

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LARRY, LEWIS
2. Date of Death Month/Day/Year: 12/06/2003
3. Time of Death: 1230 AM
4a. Facility Name (If not institution, give street and number): Future Care Charles Village
4b. City, Town, or Location of Death: BALTO.
4c. County of Death:

**Funeral Director**

5. Social Security Number: 227-90-5686
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 43 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-29-60
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4000 OAKWOOD AVE
10f. Zip Code: 21216
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): KEMP LEWIS
18. Mother's Name (First, Middle, Maiden Surname): ELSIE KENDRED

19a. Informant's Name/Relationship (Type, Print): ELLA POPE SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 1431 POTOMAC HGHTS DR FT. WASH MD

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SOUTHVIEW CEM.
Date: 12-11-03
20c. Location - City or Town, State: FRANKLIN VA.

21. Signature of Funeral Service Licensee: Wesley Chavis Jr.
22. Name and Address of Facility: WESLEY CHAVIS JR. FUNERAL HOME 2001 EASTERN AVE BALTO. MD 21231

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PERICARDIAL EFFUSION
Due to (or as a consequence of):
b. ACQUIRED IMMUNE DEFICIENCY SYNDROME
Due to (or as a consequence of):
c. PLEURAL EFFUSION
Due to (or as a consequence of):
d. THROMBOCYTOPENIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D47405
29d. Date signed (Month, Day, Year): 12/9/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LIAQAT ALI 821 N. Eutaw St. Baltimore MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41099

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Johnie McCoy Mitchell
2. Date of Death (Month, Day, Year): December 14, 2003
3. Time of Death: 7:00 P M
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 243-40-3908
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 4, 1930
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1805 Ruxton Ave.
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: General Refactory

17. Father's Name (First, Middle, Last): Johnie Mitchell
18. Mother's Name (First, Middle, Maiden Surname): Ella Mae Everett

19a. Informant's Name/Relationship (Type, Print): Mrs. Zelda Mitchell (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1805 Ruxton Ave. Balto. Md. 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lorraine Park
Date: 12/20/2003
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Sepsis
Due to (or as a consequence of):
Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Cardiomyopathy
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: 89491
29d. Date signed (Month, Day, Year): 12/14/2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lisa Billars, MD c/o Maryland General Hospital

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature:

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Mitchell, Johnie
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41100

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Minerva S. Masincup | December 18 2003 | 8:26 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Carroll Hospital Center | Westminster | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-22-0954 | 1☐M 2☒F | 92 Yrs. | | | Aug 27, 1911 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Carroll | Sykesville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 710 Obrecht Road | 21784 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Mathematician | Dept of the Army |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Adie Black | Mabel Eva |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ms. Viola Woodward (Friend) | 7200 Third Avenue Sykesville, MD 21784 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) / Date | 20c. Location - City or Town, State |
|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Arlington Natl Cemetery 1/2/2004 | Arlington, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Brian L. Haight | HAIGHT FUNERAL HOME & CHAPEL PA (Box 195) Sykesville, MD 21784 (410)-795-1400 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | Days |
| Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation,
Mitral Regurgitation,
Congestive Heart Failure

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D33184 | December 18, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jonathan Kushner 114 Business Center Drive Reisterstown, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Lance Mitchell
03-08058
RPD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41101

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Lance | Mitchell | December 14, 2003 | 1054 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University Hospital | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 074-58-0893 | 1 XX M 2 ☐ F | 37 Yrs. | | | 1/22/1966 | New York |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Pasadena | 1 ☐ Yes 2 XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8017 Escalon Avenue | 21122 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: | 1 ☐ Yes 2 XX No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Construction worker | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Donald M. Mitchell, Sr. | Jeanne Sorrell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Donald M. Mitchell, Sr.(Father) | 409 Earl Avenue, Oneida, NY 13421 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | St. Agathas Cemetery | 19 Dec 2003 | Canastota, NY |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Kelly Gregory Fink M01142 | FINK FUNERAL HOME, PA 426 Crain Hwy., S, Glen Burnie, MD 21061 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Injuries

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 ☐ No | 1 X Yes 2 ☐ No |

25. Was case referred to medical examiner? XX Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☐ Natural 2 X Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| 12/14/03 | 752 P M | 1 ☐ Yes 2 X No | Subject pedestrian struck by vehicle |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2801 Mountain Road, Pasadena, Maryland

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Theodore M. Kiger MD | O.C.M.E. | December 15, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Theodore M. Kiger MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exar must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 [illegible] 02

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROBERT MEARS
2. Date of Death: Month 12 Day 17 Year 2003
3. Time of Death: 2355 M
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE, MD
4c. County of Death:

**Funeral Director**

5. Social Security Number: 213-36-9446
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 9, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7 Goeller Ave.
10f. Zip Code: 21224
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): [illegible] College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): n/a
16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): Grayson Finley Mears
18. Mother's Name (First, Middle, Maiden Surname): Marguerite Lord

19a. Informant's Name/Relationship (Type, Print): Alber Mears, Sr. /brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 800 Southerly Drive # 215, Towson, MD 21286

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Svc. Corp.
Date: 12/19/2003
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Stephen Coster [signature] MO1122
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ol dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. BRAIN HERNIATION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. RIGHT MCA STROKE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time ol death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION, DIABETES

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28l. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title ol certifier: [signature] MD
29c. License number: RES-0001
29d. Date signed (Month, Day, Year): 12/18/03

30. Name and address ol person who completed cause ol death (Item 23a) (Type, Print): MAT FROENSCH 4940 EASTERN AVE BALTIMORE, MD 21224

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: [signature]

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 W103

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: David E. McDonough

2. Date of Death (Month, Day, Yeer): DECEMBER 15 2003

3. Time of Death: 4:18 AM

4e. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-40-8572

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: June 11, 1943

9. Birthplace *(State or Foreign Country)*: MD

Usuel Residence of Decedent

10a. Stete: MD

10b. County: N/A

10c. City, Town or Locetion: Baltimore City

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street end Number: 1150 Hull Street

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 6 / College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Longshoreman

16b. Kind of Business/Industry: Shipping

17. Father's Name *(First, Middle, Last)*: Unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary McDonough

19a. Informant's Name/Relationship *(Type, Print)*: Ann F. McDonough / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1150 Hull Street, Baltimore MD 21230

20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☒ Other *(Specify)* Entombment

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Cedar Hill Cemetery

Date: December 18, 2003

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. ACUTE CARDIAC FAILURE

Due to (or as a consequence of):

b. SEPSIS — 8 days

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

c. CARDIAC GRAFT DEHISCENCE — 6 HOURS

Due to (or as e consequence of):

d. POST OPEN HEART SURGERY — 10 days

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☑ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpetient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and Tile of certifier: MD

29c. License number: D40372

29d. Date signed *(Month, Day, Yeer)*: DECEMBER 15, 2002

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): JOHN C. LASCHINGER, M.D. 7505 OSLER DR. SUITE 410. TOWSON MD 21210

**State Registrar**

31. Dete filed *(Month, Day, Yeer)*: DEC 19 2003

32. Registrar's Signature

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 [illegible]

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): **Beatrice Leona Mongold**

2. Date of Death (Month, Day, Year): December 12 2003

3. Time of Death: 22:00 M

4a. Facility Name (If not institution, give street and number): St. Agnes Healthcare

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 217.50.7621

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 22, 1949

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 4208 Leeds Avenue

10f. Zip Code: 21229

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): food service

16b. Kind of Business/Industry: restaurant

17. Father's Name (First, Middle, Last): Robert B. Cross

18. Mother's Name (First, Middle, Maiden Surname): Janet L. Johns Wiles

19a. Informant's Name/Relationship (Type, Print): Ms. Teresa L. Allen Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4208 Leeds Avenue Baltimore, MD 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Good Shepherd Cemetery

Date: 12/18/2003

20c. Location - City or Town, State: Ellicott City, Maryland

21. Signature of Funeral Service Licensee: [signature] 100520

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic breast carcinoma — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D47353

29d. Date signed (Month, Day, Year): December 12, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jon Falck MD St. Agnes Hospital 900 Caton Avenue Baltimore, Maryland 21229

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature: [signature]

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MONGOLD, BEATRICE L.
Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41105

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Elena Okas | Dec 17 2003 | 1530 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1250 Elm Road | Baltimore | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-30-4873 | 1☐M 2☒F | 70 Yrs. | | | Sept 8, 1933 | Lithuania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1250 Elm Road | 21227 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Clerk | Utilities |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jouzas Burniauskas | Margarita Burniauskas |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Elena Langan / Daughter | 11 Island Avenue, Unit 1611, Miami Beach, Fl 33139 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Loudon Park Cemetery | 12/20/2003 | Baltimore, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC SMALL CELL CARCINOMA OF LUNG | 2 YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature] Dr. Griffiths, MD

29c. License number D0019419

29d. Date signed (Month, Day, Year) DECEMBER 19, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Diana Griffiths, M.D. 900 Caton Avenue, Baltimore, Maryland 21229

**State Registrar**

31. Date filed (Month, Day, Year) DEC 19 2003

32. Registrar's Signature ▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41106

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Agnes Orlando

2. Date of Death (Month, Day, Year): Dec. 16 2003

3. Time of Death: 6:28 PM

4a. Facility Name (If not institution, give street and number): Manor Care Roland Park

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 209-24-7612

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 22, 1910

9. Birthplace (State or Foreign Country): Mt. Carmel, PA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 4669 Falls RD.

10f. Zip Code: 21209

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 08 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Motor Repair

16b. Kind of Business/Industry: Machine Shop

17. Father's Name (First, Middle, Last): Thomas Kulick

18. Mother's Name (First, Middle, Maiden Surname): Ann Gabin

19a. Informant's Name/Relationship (Type, Print): Joan Karpinski, DTR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 56 Knollwood Drive, Deptford, NJ 08096

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Marys Cemetery

Date: 12/20/2003

20c. Location - City or Town, State: Kulpmont, PA

21. Signature of Funeral Service Licensee: ▶ R. H. Ruck

22. Name and Address of Facility: RUCK TOWSON FUNERAL HOME, INC. 1050 YORK ROAD TOWSON, MD., 21204

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D16619

29d. Date signed (Month, Day, Year): DEC. 17, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. VERGARA-SOARES 4669 FALLS RD. BALTIMORE, MD. 21209

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature: ▶

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To Be Completed by Funeral Director**

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41107

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Monica Parnell
2. Date of Death (Month, Day, Year): December 16 2003
3. Time of Death: 2140 M
4a. Facility Name (If not institution, give street and number): ST. Agnes HealthCare
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-82-4993
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 42 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-7-61
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1250 N. Augusta Ave.
10f. Zip Code: 21229
10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th GRADE
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK
16b. Kind of Business/Industry: State of MD.

17. Father's Name (First, Middle, Last): John W. Parnell
18. Mother's Name (First, Middle, Maiden Surname): Ethel Davis

19a. Informant's Name/Relationship (Type, Print): Travis Rice (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 605 N. Carey Street Balto, MD 21217

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WESTERN
Date: 12-23-03
20c. Location - City or Town, State: Balto. MD.

21. Signature of Funeral Service Licensee: Vaughn C. Greene
22. Name and Address of Facility: Vaughn C. Greene Funeral Srvc. 5151 Balto. Nat'l Pike, Balto. MD 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Sepsis
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death: Days

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Melissa K Buick
29c. License number: D0036765
29d. Date signed (Month, Day, Year): December 17 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Melissa K Buick, M.D. - ST. Agnes Healthcare - 900 Caton Avenue - Baltimore, Maryland 21229

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Parnell, Monica

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41108

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Pickney
2. Date of Death (Month, Day, Year): DECEMBER 17, 2003
3. Time of Death: 6:28 A M
4a. Facility Name (If not institution, give street and number): Sinai hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 248-72-6407
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-10-1945
9. Birthplace (State or Foreign Country): SC

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTO
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3703 Milford Ave
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Elliott Pickney
18. Mother's Name (First, Middle, Maiden Surname): Lizzie Dobson

19a. Informant's Name/Relationship (Type, Print): Elliott Pickney, BRO
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3703 Milford Ave, Balto, MD 21207

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 12-22-03
20c. Location - City or Town, State: Maryland

21. Signature of Funeral Service Licensee: Willie E Howell Jr
22. Name and Address of Facility: Howell Funeral Home 4600 Liberty Hgts. Balto, MD 21207

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death):
a. Gastrointestinal Bleeding
Due to (or as a consequence of):
b. Hepatic encephalopathy
Due to (or as a consequence of):
c. Acute Renal failure
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death: 3 days

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: A Gupta MD.
29c. License number: RES-000
29d. Date signed (Month, Day, Year): December 17, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type. Print): ADITI GUPTA, MD, SINAI HOSPITAL, BALTIMORE, MD

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Patient known as Pinkney, James

2

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41109

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Florence L. Philips

2. Date of Death: Month Dec Day 16 Year 2003

3. Time of Death: 4:15 PM

4a. Facility Name (If not institution, give street and number): Knollwood Manor

4b. City, Town, or Location of Death: Millersville

4c. County of Death: AnneArundel

**Funeral Director**

5. Social Security Number: 214-30-6515

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 14, 1917

9. Birthplace (State or Foreign Country): Arkansas

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Crownsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 775 Snodgrass

10f. Zip Code: 21032

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Driver

16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): Allen B. Justice

18. Mother's Name (First, Middle, Maiden Surname): Julia Hale

19a. Informant's Name/Relationship (Type, Print): Betty L. Harris (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 461 Kyle Road, Crownsville, MD 21032

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 12/19/2003

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Barbara J. Arnold

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — Approximate Interval: WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Brian C. Wallace MD

29c. License number: D31136

29d. Date signed (Month, Day, Year): DECEMBER 17, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN C. WALLACE, MD, 9005 KILBRIDE ROAD, NOTTINGHAM, MD 21236

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #1&20b&c PER PHY G826 12/23/03 JH

# Certificate of Death

Reg. No. 2003 41110

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ~~Pedro Perez~~ PEDRO PEREZ
2. Date of Death (Month, Day, Year): December 15, 2003
3. Time of Death: 0550 M

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 058-50-7168
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-20-39
9. Birthplace (State or Foreign Country): DOMINICAN Rep

Usual Residence of Decedent

10a. State: Md.
10b. County:
10c. City, Town or Location: BALTO.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6435. New Kirk ST.
10f. Zip Code: 21224
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): disable
16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): RAMON PEREZ
18. Mother's Name (First, Middle, Maiden Surname): LeticiA Almonte

19a. Informant's Name/Relationship (Type, Print): MARGUERITA PEREZ wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32 ENCHANTED HILLS Apt 2 MILLS Md.

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SANTIAGO Rosenwald Cemetery
Date: 12-25-03 12-22-03
20c. Location - City or Town, State: DOMINICAN REPUBLIC ~~United St.~~

21. Signature of Funeral Service Licensee: Wesley Chavis
22. Name and Address of Facility: WESLEY CHAVIS SR- FUNERAL HOME 2007 EASTern Ave BALTO.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. congestive heart failure.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): past history of myocardial infarctions
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death:

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Panna Patel
29c. License number: 23011
29d. Date signed (Month, Day, Year): December 15, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Panna Patel, Johns Hopkins Bayview Medical Center

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: P. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 [illegible]

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ANNA MAY PASQUARIELLO | DEC. 16, 2003 | 11:16 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1931 WINDER ROAD | WOODLAWN | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-76-1838 | 1☐M 2☒F | 63 Yrs. | | | 1/28/40 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | WOODLAWN | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1931 WINDER ROAD | 21244 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| SPECIAL EDUCATION | | ASSEMBLY WORKER | FACTORY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| LEO PASQUARIELLO | SOPHIE MACK |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOHNETTA CHEATHAM | 9180 RUMSEY RD. COLUMBIA, MD. 21045 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | ST. STANISLAUS CEME. | 12/18/03 | BALTIMORE, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Eugene Kaczorowski | KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTIMORE, MD. 21224 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☑No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☑Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| E.P. Williamson M.D. | D11171 | December 17, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
E.P. Williamson 3535 Southbreeze Ellicott City [illegible]

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | [signature] |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41112

Patient known as Josephine Rafus

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JOSEPHINE RAFUS | December 10, 2003 | 23:15 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-40-1049 | 1☐M 2☒F | 66 Yrs. | | | 05-20-1937 | SC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | GWYNN OAK | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5020 DICKEY HILL RD. # C4 | 21207 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 TH GRADE | N/A | NURSE | HOSPITAL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOSEPH JONES | THELMA ROBINSON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOAN SMALL | 5727 MAPLE HILL RD., BALTO. MD 21239 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | GARRISON FOREST | 12-19-03 | OWINGS MILLS, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD 21229 |

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lactic acidosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Prolonged hypotension

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Atrial Fibrillation, Congestive heart failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Judy Shumway D.O. | RES-000 | December 10, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Judy Shumway, D.O. Sinai Hospital of Baltimore

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ [signature] |

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41113

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Maude Adeline Rogers | December 18, 2003 | 10:40 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 341 Stillwater Road | Essex | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 237-32-7684 | 1☐M 2☒F | 77 Yrs. | | | March 29, 1926 | North Carolina |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Essex | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 341 Stillwater Road | 21221 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Henry Franklin Campbell | Sarah Lee Stancell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Robin G. Rogers (Son) | P.O. Box 1641 Providencetown, Mass 02657 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Holly Hill Mem. Grdns. | Dec. 22, 2003 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Brian W. Burke | Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. pancreatic cancer | 12 mos. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| John Ottaviano MD | D40850 | December 18, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
YVONNE OTTAVIANO MD 9000 FRANKLIN SQ. DR. BALTIMORE MD 21237

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **Amend Item #19a per fh** 0826 12/19/03 tas *Certificate of Death* Reg. No. 2003 [illegible]

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| MILLICENT | RADLICK | DECEMBER 19 2003 | 0621 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 227 GREEN SPRING VALLEY RD. | OWINGS MILLS | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex 1☐M 2☐F | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 291.18.1698 | XX | 90 Yrs. | | | MARCH 17 1913 | LORAIN, OH |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits 1☐Yes 2☐No |
|---|---|---|---|
| MD | BALTIMORE | OWINGS MILLS | XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 227 GREEN SPRING VALLEY RD. | 21117 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed XX 4☐Divorced | 1☐Yes XX☒No If Yes, Give Year or Dates: | 1☐Yes XX 2☐No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| MIKE LALICH | ROSE VIGNOVICH |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ~~MELANIE SABEELHAUS~~ Melanie Sabelhaus DAUGHTER | 227 GREEN SPRING VALLEY RD. OWINGS MILLS, MD 21117 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | ST. THEODOSIUS | UNK | BROOKLYN, OH |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility | |
|---|---|---|---|
| K. GREGORY FINK | MO1148 | FINK FUNERAL HOME, P.A. | 426 CRAIN HWY. S.W. GLEN BURNIE, MD 21061 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. - Pneumonia & Sepsis. | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. - DIC | |
| | Due to (or as a consequence of): | |
| | c. - ARDS. | |
| | Due to (or as a consequence of): | |
| | d. - Alzheimers Dementia. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Dopath | D 28530 | DECEMBER 19, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DINO PATELL, M.D. 19 WALKER AVE. SUITE 202 PIKESVILLE, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41115

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ELIZABETH RUSSELL
2. Date of Death (Month, Day, Year): December 13, 2003
3. Time of Death: 9:00 A M
4a. Facility Name (If not institution, give street and number): Mariner Furnace Branch
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 578-28-7485
6. Sex: 1☐ M XX F
7. Age (In yrs. last birthday): 99 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6/3/1904
9. Birthplace (State or Foreign Country): VIRGINIA

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Hanover
10d. Inside City Limits: 1☐ Yes 2 XX No
10e. Street and Number: 7531 Moraine Drive
10f. Zip Code: 21076
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Government
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): William Reynolds
18. Mother's Name (First, Middle, Maiden Surname): Janie Clark

19a. Informant's Name/Relationship (Type, Print): Cora Squalls-Moreland
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7531 Moraine Drive, Hanover, MD 21076

20a. Method of Disposition: 1 XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Mem. Park
Date: 12/17/2003
20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: ▶ Kelly Gregory Fink #MO1148
22. Name and Address of Facility: FINK FUNERAL HOME, PA 426 Crain Hwy., S, Glen Burnie, MD 21061

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CONGESTIVE CARDIOMYOPATHY | 5 years |
| Due to (or as a consequence of): | b. ATHEROSCLEROSIS | 20 years |
| Due to (or as a consequence of): | c. HYPERTENSION | 50 years |
| Due to (or as a consequence of): | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2 XX No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
OSTEOARTHRITIS

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2 X No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2 X No

25. Was case referred to medical examiner? 1☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4 X Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1 X Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Richard E Fisher MD
29c. License number: D02519
29d. Date signed (Month, Day, Year): Dec 15 03
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RICHARD E FISHER MD CRAIN TOWERS GLEN BURNIE MD

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: ▶

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Clifton Shields
03-08062
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **Unpend Item #23a,27&28a-f per me 6827 1/21/04 tas**

# Certificate of Death

Reg. No. 2003 4116

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| CLIFTON SHIELDS | December 15, 2003 | 5:45 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical Center | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 217-67-8162 | 1☒M 2☐F | 0 Yrs. | 3 | 18 | | | August 27 2003 | MARYLAND |

2830

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 933 BETHUNE RD | 21225 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 0yrs | | N/A | N/A |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CLIFTON D SHIELDS | SHERISE NUTT |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Clifton D. Shields/Father | 2431 Seamon Ave., Baltimore, Maryland 21225 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | MT ZION CEMETERY | 12-20-03 | LANSDOWNE,MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Charles H Powell | WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SUDDEN UNEXPLAINED DEATH IN INFANCY | |
| Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined | Found 12/15/03 | Found at 4:00 A M | 1☐Yes 2☒No | UNKNOWN |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| FOUND AT RESIDENCE | 933 BETHUNE ROAD BALTIMORE, MARYLAND |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Ling Li. M.D | O.C.M.E. | December 16, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ling Li, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41117

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Nelson William Strange Sr.
2. Date of Death: Month 12 Day 18 Year 03
3. Time of Death: 3:55 AM
4a. Facility Name (If not institution, give street and number): FREDERICK VILLA
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 228-24-8699
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-17-26
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 711 Academy RD
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th GRADE
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): REPAIRMAN
16b. Kind of Business/Industry: Appliances

17. Father's Name (First, Middle, Last): Nelson Strange
18. Mother's Name (First, Middle, Maiden Surname): Annie M. Singleton

19a. Informant's Name/Relationship (Type, P...): BRENDA WILKINS (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or ..., State, Zip Code): 6429 Clifton Forge Cir., Baltimore, MD 21228

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount
Date: 12-19-03
20c. Location - City or Town, State: Balto. MD.

21. Signature of Funeral Service Licensee: Vaughn C Green
22. Name and Address of Facility: Vaughn C Green Funeral Svc. 5151 Balto. Nat'l Pike, Balto. MD 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — Due to (or as a consequence of): — Approximate Interval: days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia
Coronary artery disease
Hypertension

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ATTENDING PHYSICIAN
29c. License number: D-40521
29d. Date signed (Month, Day, Year): December 19, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. OHANEY 3350 Wilkens Avenue Suite 302 Baltimore, MD 21229

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: Barbara G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41118

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Benjamin Anderson Smith

2. Date of Death: Month December Day 13 Year 2003

3. Time of Death: 2135

4a. Facility Name (If not institution, give street and number): Baltimore VA Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-03-8736

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03-24-1918

9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BAITimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2007 E LANVale ST

10f. Zip Code: 21213

10g. Citizen of What Country? U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER

16b. Kind of Business/Industry: COPPERWORKS

17. Father's Name (First, Middle, Lest): BENJAMIN A SMITH

18. Mother's Name (First, Middle, Maiden Surname): HELEN Taylor

19a. Informant's Name/Relationship (Type, Print): DOROTHY E SMITH,

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 2007 E LANVale St, Balto MD 2123

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRison FOREST | Date: 12-22-03

20c. Location - City or Town, State: Owings Mills MD.

21. Signature of Funeral Service Licensee: Rosie M. Smith

22. Name and Address of Facility: Howell-Linear Home 4600 LIBERTY HTS Balto MD 21207

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 16 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Deep Vein Thrombosis

Hypertension

Anemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted. 2 [ ] **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mollie M Davis

29c. License number: P16729

29d. Date signed (Month, Day, Year): 12/13/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mollie M Davis 20 South Greene St. Baltimore, MD 21230

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature

**Baltimore, Maryland 21215-0020**

permit. Pegas 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours efter death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41119

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Margaret | Ann | Stewart | December 18, 2003 | 4:00 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 32 Henderson Road | Middle River | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 236 38 9427 | 1☐M 2☒F | 76 Yrs. | | | Oct. 15, 1927 | West Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Middle River | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 32 Henderson Road | 21220 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Cecil Roscoe Holston | Nannie Lucas |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| David Stewart Husband) | 32 Henderson Road Baltimore Maryland 21220 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Holly Hill Mem. Gardens | 12/20/03 | Baltimore County, Md. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home PA, 1407 Old Eastern Avenue Essex Maryland 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTOTIC NSCLC (NON-small cell LUNG CANCER) | 2 mos |
| Due to (or as a consequence of): | b. BRAIN METASTASES | 2 mos |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | |
| Due to (or as a consequence of): | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D33551 | 12/18/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL AUERBACH, 9110 FRANKLIN SQ. DR. #314, BALTIMORE, MD 21237

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41120

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| KING | SOLOMON | SELLERS | DECEMBER 15, 2003 | 11:22 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Southern Maryland Hospital | Clinton | Prince Georges |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577-30-0731 | XX 1 M 2 F | 79 Yrs. | | | 4/30/1924 | South Carolina |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Charles | Waldorf | XX 1 Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3260 Ryon Court | 20601 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married XX Widowed 4 Divorced | 1 Yes XX No If Yes, Give Year or Dates: | 1 Yes 2 XX No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 5 | | Cement Finisher | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Willie Sellers | Alene McMillian |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Cora Knox - Daughter | 105 Hialeah Drive, Cheraw, SC 29520 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| XX 1 Burial 2 Cremation XX 3 Removal from State 4 Donation 5 Other (Specify) | Montrose Cemetery | JUNE | Cheraw, SC |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Kelly Gregory Fink #MO1148 | FINK FUNERAL HOME, PA 426 CRAIN HWY., S, GLEN BURNIE, MD 21061 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE MYOCARDIAL INFARCTION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 ☑ No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ☑ ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 ☑ Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| T. JODRIE | D40324 | DECEMBER 15, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TERRY JODRIE, MD 7503 SURRATTS ROAD, CLINTON, MARYLAND 20735

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner / must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

12/15/03 @ 11:22

Sellers King expired

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41121

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Evelyn Helena Stumpfel | December 15, 2003 | 8:10 p. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Good Samaritan Nursing Center | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-20-9334 | 1☐ M 2☒ F | 89 Yrs. | | | Aug. 28, 1914 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3209 Berkshire Road | 21214 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 yrs. | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harvey F. Mayes | Emma Hofheiser |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Robert J. Mayes / Nephew | 3209 Berkshire Road Baltimore, Maryland 21214 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Meadowridge Mem. Park | 12/19/2003 | Elkridge, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael E. Canapp | Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure — 3d

Due to (or as a consequence of):
b. Acute Bronchitis, Viral — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Charles F. Hoesch, Jr. | D 20390 | 12/11/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles Hoesch, M.D. 5601 Loch Raven Blvd Russell Morgan Bldg. Balto., MD 21239

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | Linda G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Gertrude Jackson Smith
03-08093
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41122

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gertrude Jackson Smith
2. Date of Death (Month, Day, Year): December 16, 2003
3. Time of Death: 10:10 A M
4a. Facility Name (If not institution, give street and number): 1212 Winston Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-26-3204
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 2, 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1212 Winston Ave
10f. Zip Code: 21239
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 2½
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Legal

17. Father's Name (First, Middle, Last): Leroy Jackson
18. Mother's Name (First, Middle, Maiden Surname): Dorothy Gray

19a. Informant's Name/Relationship (Type, Print): Dehaven Smith husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1212 Winston Ave. Balto. Md. 21239

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory
Date: 12-18-2003
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Carlton C. Douglas
22. Name and Address of Facility: Douglas Funeral Service P.A. 1201 McCulloh St. Balto. Md. 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Zabillah MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 17, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ZABILLAH MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 4 1129

SPAYD, THERESA

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Therese | Marie | Spayd | December 14 2003 | 4:45P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| North Arundel Hospital | Glen Burnie | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 204-14-7399 | 1☐ M 2☒ F | 78 Yrs. | | | Dec. 3, 1925 | Maine |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Gambrills | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2278 Dairy Farm Road | 21054 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Adjutor Brochu | Emelienne Roux |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| LeRoy Spayd, Jr. (Son) | 2333 Dartmouth Lane, Crofton, MD 21114 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Ebenezer Cemetery | 12/20/2003 | Lebanon, PA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Patrick J. Arnold | Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D48806 | December 14th, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KOFI BONITEY 301 Hospital Dr., Glen Burnie, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41124

**Physician /Medical Examiner**

**Funeral Director**

1. Decedent's Name *(First, Middle, Last)*: Aria Lee Shirley

2. Date of Death — Month: December; Day: 16; Year: 2003

3. Time of Death: 530AM

4a. Facility Name *(If not institution, give street and number)*: Larien D Ridgs Dr

4b. City, Town, or Location of Death: Belcamp

4c. County of Death: HARFORD

5. Social Security Number: 292-28-7947

6. Sex: 1☐ M 2☒F

7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 31, 1929

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Abingdon

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3214 Holly Knoll Court

10f. Zip Code: 21009

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Factory Worker

16b. Kind of Business/Industry: China Manufacturer

17. Father's Name *(First, Middle, Last)*: William Samuel Golding

18. Mother's Name *(First, Middle, Maiden Surname)*: Julia (unk) Snow

19a. Informant's Name/Retationship *(Type, Print)*: Kathie V. Ashley / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3214 Holly Knoll Ct., Abingdon, Maryland 21009

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Beaver Cemetery

Date: 12-22-03

20c. Location - City or Town, State: Midland, Pennsylvania

21. Signature of Funeral Service Licensee: Stephen A Kreeger

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular disease — 7 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturet 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D28339

29d. Date signed *(Month, Day, Year)*: December, 16 2003

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Linda Freilich 101 E. Wheel Rd Bel Air MD 21015

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 19 2003

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

ARIA L SHIRLEY

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41125

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JEREMIAH FRANCIS SULLIVAN, SR.

2. Date of Death (Month, Day, Year): Dec. 16, 2003

3. Time of Death: 3:30 PM

4a. Facility Name (If not institution, give street and number): 3701 Fait Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 216-36-8822

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 27, 1939

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3701 Fait Avenue

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator

16b. Kind of Business/Industry: Pet Store

17. Father's Name (First, Middle, Last): Jeremiah John Sullivan

18. Mother's Name (First, Middle, Maiden Surname): Nellie Wickman

19a. Informant's Name/Relationship (Type, Print): Barbara Sullivan (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3701 Fait Avenue Baltimore, Maryland 21224

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith

Date: 12/20/03

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Eugene Kaczorowski

22. Name and Address of Facility: Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md 21222

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio Vascular Collapse — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic Esophageal Cancer — Due to (or as a consequence of): — 8 Months

c. — Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- Hypertension
- Diabetes Mellitus
- Coronary Art. Disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Diaa Mikhail MD

29c. License number: D 51883

29d. Date signed (Month, Day, Year): December 17, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Diaa Mikhail, M.D. 1005 North Point Blvd. #708 Baltimore, Md. 21224

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41126

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| **Sabra Sullivan** | December 10, 2003 | 6:30 a. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Rose Manor Assisted Living | Ellicott City | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578.24.1001 | 1☐M 2☒F | 101 Yrs. | | | February 13, 1902 | Washington, DC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Howard | Highland | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 13185 Highland Rd. | 20777 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Teacher | Education |
| | 2 | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John B. Harry | Sabra Woodward |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. John Sullivan Son | 13185 Highland Rd. Highland, Maryland 20777 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | All County Cremation Services, Inc. | 12/11/2003 | Sykesville, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Melody Tucker MD1293 | Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. DEMENTIA | 5 years. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Assisted Living |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D0042680 | December 10, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SABA SIDDIKI M.D 9051 BALTIMORE NATL PIKE #4C ELLICOTT CITY MD 21042

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41127

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Barbara | Taylor | December 13 2003 | 5:05 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 563-88-3296 | 1 ☐ M 2 ☒ F | 60 Yrs. | | | 04-20-1943 | LOUISIANA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTO | 1 ☒ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2500 W. Belvedere | 21215 | U.S.A |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | NURSES AIDE | MEDICAL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Henry Moore | Hazel Giddery |

| 19a. Informant's Name / Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Irvin Taylor | 2500 W. Belvedere Ave, Balto MD 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Woodlawn Crematory | 12-22-03 | Colma, CA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Willie Ellowell Jr | 4600 Liberty Heights Blvd. MD 21207 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. End Stage Renal Disease | 5 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Pericardial Effusion | 2 days |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medicel Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] M.D. | RES-000 | December 13, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Laura Y. McGirt M.D. Johns Hopkins Hospital, Tower 110, Doctors Lounge, 600 North Wolfe Street, Baltimore, Maryland 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41128

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Goldie Thomas
2. Date of Death: Month 12 Day 13 Year 03
3. Time of Death: 10:15AM
4a. Facility Name (If not institution, give street and number): Caton Manor Nsg Home
4b. City, Town, or Location of Death: CATONSVILLE
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 217-34-9586
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-12-1933
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4422 PENLUCY RD.
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 TH GRADE | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PACKER
16b. Kind of Business/Industry: MANUFACTURING

17. Father's Name (First, Middle, Last): ROBERT WILMORE
18. Mother's Name (First, Middle, Maiden Surname): BELLAH HOWARD

19a. Informant's Name/Relationship (Type, Print): CAROLYN PAYNE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4422 PENLUCY RD. BALTO. MD 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN
Date: 12.18.03
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident
Due to (or as a consequence of):
b. Hypertension
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hyp Pulmonary Embolism

23b. Did tobacco usa contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DC Golya
29c. License number: D17537
29d. Date signed (Month, Day, Year): 12-13-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DARSHAN S. SALUJA MD, 1600 W MOUNT Royal Ave, Balto

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: Geneva G Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41129

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Bertha Eleanor Villa | DECEMBER 16 2003 | 18:25 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Union Memorial Hospital | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-16-7951 | 1☐M 2☒F | 79 Yrs. | | | Feb 23 1924 | Md |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md | Baltimore | Halethorpe | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5907 Oakland Road | 21227 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 3 | homemaker | domestic |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Earl Woollen | Bertha Richardson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joseph C. Villa (spouse) | 5907 Oakland Rd., Halethorpe, Md 21227 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | All County Cremation | 12-18-03 | Sykesville, Md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Paige Haight Herbert | Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. MYOCARDIAL INFARCTION | 12 HOURS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ REAZ SIDDIQUI, MD | AT 2438946-C10 | DECEMBER 16, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
REAZ SIDDIQUI 201 EAST UNIVERSITY PARKWAY, BALTIMORE, MD 21218

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item#10cperFHG826 12/19/03 EW

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41130

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| DORIS L. WATSON | 12 / 13 / 2003 | 0344 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| KERNAN HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-18-3463 | 1☐M 2☑F | 79 Yrs. | | | 06, 15, 1924 | NC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | BALTIMORE | ~~Baltimore~~ Gwynn Oak | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7310 FAIRBROOK ROAD #2D | 21244 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☑Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 TH GRADE | N/A | HOME MAKER | DOMESTIC |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| NELLO EDMOND | LUCY SMITH |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ELLA BROWN | 4111 WALRAD ST. BALTO. MD. 21229 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | CEDAR HILL | 12-18-03 | BALTO. MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 21229 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | 5 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☐No | 1☐Yes 2☑No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☑Yes 2☐No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D0044635 | 12, 13, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John Harrison MD 2200 Kernan Drive Baltimore, MD. 21207

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 [illegible]

GERALD WAYNE WALTER
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gerald Wayne Walter
2. Date of Death: Month December Day 12 Year 2003
3. Time of Death: 1822 M
4a. Facility Name (If not institution, give street and number): Carroll Hospital Center
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 219-38-2498
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 1 1941
9. Birthplace (State or Foreign Country): Md

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Md
10b. County: Carroll
10c. City, Town or Location: Eldersburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 628 Green Valley Way
10f. Zip Code: 21784
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1965-1971
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): pressman
16b. Kind of Business/Industry: Bureau of Engraving

17. Father's Name (First, Middle, Last): Howard Albert Walter Sr.
18. Mother's Name (First, Middle, Maiden Surname): Dorothy Cook

19a. Informant's Name/Relationship (Type, Print): Sharen Walter (spouse)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 628 Green Valley Way, Eldersburg, Md 21784

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Paul's Lutheran
Date: 12-17-03
20c. Location - City or Town, State: Upperco, Md

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert
22. Name and Address of Facility: Haight Funeral Home & Chapel
P.O.Box 195 Sykesville, Md 21784

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease — Due to (or as a consequence of): — 10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Chronic Renal Failure — Due to (or as a consequence of): — 7 yrs
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No ~~3~~ Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes ~~2~~ No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes ~~2~~ No
26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient ~~2~~ ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: ~~1~~ Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ~~1~~ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D0019317
29d. Date signed (Month, Day, Year): 12/16/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BORIS KREZNER, 1838 GREEN TREE RD, BALTIMORE, MD 21208

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: ▶ [signature]

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar AMEND ITEM #9 PER FH G826 12/29/03 JH &26

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41132

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Emma Kate Wilder

2. Date of Death: Month December Day 18 Year 2003

3. Time of Death: 16:15 M

4a. Facility Name (If not institution, give street and number): 3101 Old Westminster Pike

4b. City, Town, or Location of Death: Finksburg

4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 219-42-6445

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~Dec 19, 1928~~ 2-19-28

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: WV

10b. County: Marion

10c. City, Town or Location: Fairmont

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 604½ Willow Avenue

10f. Zip Code: 26591

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Certified Nursing Assistant

16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): James B. Cope

18. Mother's Name (First, Middle, Maiden Surname): Roxie McCurry

19a. Informant's Name/Relationship (Type, Print): Mrs. Carol Carder (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3101 Old Westminster Pike, Finksburg, MD 21048

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Beech Grove Cemetery

Date: 12/22/03

20c. Location - City or Town, State: Jonesville, VA

21. Signature of Funeral Service Licensee: Brian R. Haight

22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC CARCINOMA — 2 1/2 Weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ENDOMETRIAL CARCINOMA of UTERUS — 2 months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) DAUGHTER's RESIDENCE

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chitrachedy Naganna

29c. License number: D0018200

29d. Date signed (Month, Day, Year): 12-19-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHITRACHEDY NAGANNA MD 700 A Poole Rd WESTMINSTER MD 21157

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4A-10E-26

5

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41133

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John T. Walsh, Jr.
2. Date of Death (Month, Day, Year): December 15, 2003
3. Time of Death: 11:45 PM
4a. Facility Name (If not institution, give street and number): Blakehurst
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 339-22-7745
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 27 1929
9. Birthplace (State or Foreign Country): Illinois

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1055 W. Joppa Rd. #204
10f. Zip Code: 21204
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): +2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Customs Agent
16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): John T. Walsh, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Maragret O'Donnell

19a. Informant's Name/Relationship (Type, Print): Lynn Walsh/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8609 Heather Mill Rd. Perry Hall, Md. 21236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Prospect Hill Cem.
Date: 12-19-03
20c. Location - City or Town, State: Towson, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, injury, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC LUNG CANCER — 5 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE
ATRIAL FIBRILLATION

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [✓] Other (Specify) ASSISTED LIVING

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D30433
29d. Date signed (Month, Day, Year): DEC, 17, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY MD GORMLEY 6701 N CHARLES ST BALTIMORE MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: [signature]

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41134

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Lorraine C. Wasowicz | 12 / 16 / 2003 | 12:10P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| BROADMEAD | COCKEYSVILLE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|
| 218-18-7470 | 1☐ M 2☒ F | 82 Yrs. | | 10-07-1921 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | BALTIMORE | SPARKS | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12 THE STRAND | 21052 | U. S. A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 YEARS | HOUSEWIFE | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CHARLES COOK | ELIZABETH WENGER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ELIZABETH W. METTEE (DAUGHTER) | 12 THE STRAND, SPARKS, MARYLAND, 21052 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | MORELAND MEM. PARK | 12-18-2003 | PARKVILLE, MD.,21234 |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ R. H. Ruck | RUCK TOWSON FUNERAL HOME, INC. 1050 YORK ROAD TOWSON, MD., 21204 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

a. CONGESTIVE Heart Failure — 5 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. _____

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | Month / Day / Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

bronchogenic carcinoma

Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D50232 | 12/16/3 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYRUS HAMIDI, MD 13801 YORK RD COCKEYSVILLE, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2003 41135

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Lee Watson, Jr.

2. Date of Death (Month, Day, Year): December 15 2003

3. Time of Death: 1:38 PM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 220-66-1396

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 23, 1954

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severn

10d. Inside City Limits: 1 ☐ Yes 2 XX No

10e. Street and Number: 119 Gambrills Road

10f. Zip Code: 21144

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Freight

17. Father's Name (First, Middle, Last): Robert Lee Watson

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Anna VanMeter

19a. Informant's Name/Relationship (Type, Print): Elizabeth Drury (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Lot 67 Rol-Park, Trailer Village, Millersville, MD 21108

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Cemetery

Date: 12/19/2003

20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer with Brain Metastasis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pleural and Pericardial Effusions

Due to (or as a consequence of):

c. Renal and Liver Insufficiency

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ George E. Wicks III M.D.

29c. License number: 041365

29d. Date signed (Month, Day, Year): December 15, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George E. Wicks III M.D. 301 Hospital Drive Glen Burnie, MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature: ▶ [signature]

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Watson, Robert

DHMH 17 Rev 1/2001

ORIGINAL

DOS
03-8066
Edward Whittaker

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41136

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Edward | Whitaker | December 14 2003 | 1703 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-04-2788 | 1 [X] M 2 [ ] F | 35 Yrs. | | | Aug. 16, 1968 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| SC | Greenville | Mauldin | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8 Winery Court | 29662 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Mechanic | Diesel |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Richard L. Whitaker | Mary Ruth Hounshell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Tina M. Whitaker (Wife) | 8 Winery Court, Mauldin, SC 29662 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Hillcrest Cemetery | 12/19/2003 | Annapolis, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Carbon Monoxide intoxication | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [X] Yes 2 [ ] No | 1 [X] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| [X] Yes 2 [ ] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 12-14-03 | Found 1630 Pm M | 1 [ ] Yes 2 [X] No | Subject inhaled exhaust fumes from a generator |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| At home | 64 Silopanna Rd Annapolis MD |

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] M.D | OCME | December 16 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LING LI M.D 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | [signature] |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41137

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ella Eliva Williams
2. Date of Death (Month, Day, Year): December 16 2003
3. Time of Death: 10:40 A.M.
4a. Facility Name (If not institution, give street and number): North Arundle Hospital
4b. City, Town, or Location of Death: Maryland
4c. County of Death: Anne Arundle County

**Funeral Director**

5. Social Security Number: 215-28-3406
6. Sex: 1☐M 2☑F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-25-32
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 2715 Mura Street
10f. Zip Code: 21213
10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Nursing

17. Father's Name (First, Middle, Last): Hempsnal Syndnor
18. Mother's Name (First, Middle, Maiden Surname): Mabel Swell

19a. Informant's Name/Relationship (Type, Print): Warren Williams
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2715 Mura St Balto maryland 21213

20a. Method of Disposition: 1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery
Date: 12-30-03
20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: Patricia Betts
22. Name and Address of Facility: Betts Funeral Home 1129 N. Caroline St Balto mD 21213

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Chronic Obstructive pulmonary disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D43977
29d. Date signed (Month, Day, Year): December 16 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anupam Dhingra 301 Hospital Drive, Glen Burnie MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

ELLA WILLIAMS

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41138

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Dorothy Elizabeth Watson | December 17, 2003 | 0117 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Union Hospital | Elkton | Cecil |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-30-3898 | 1☐ M 2☒ F | 70 Yrs. | | | Apr. 13, 1933 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Joppa | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 305 Barksdale Road | 21085 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Anthony Peter Arigo | Dorothy Elizabeth Belt |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ronda L. Kamahele / Daughter | 39 Crestwood Drive, Elkton, Maryland 21921 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Baltimore Nat'l Cem. | 12-22-03 | Baltimore, Maryland |

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: McComas Funeral Home, P.A 1317 Cokesbury Road, Abingdon, Maryland 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. RESPIRATORY FAILURE | 1 WEEK |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. PNEUMONIA | 1 WEEK |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE, MALNUTRITION

23e. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D0051197 | DECEMBER 17, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Maya Gupta 110 W 9th STREET, #320, WILMINGTON, DE 19801

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41139

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILLIAM FRANCIS WEYANT

2. Date of Death Month Day Year: DEC 14, 2003

3. Time of Death: 13:57 M

4a. Facility Name (If not institution, give street and number): UPPER CHESAPEAKE MEDICAL CENTRE

4b. City, Town, or Location of Death: BEL AIR

4c. County of Death: HARFORD

**Funeral Director**

5. Social Security Number: 213-30-8085

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 24, 1933

9. Birthplace (State or Foreign Country): Pennsylvania

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Abingdon

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4036 Abingin Drive

10f. Zip Code: 21009

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): Bernard Francis Weyant

18. Mother's Name (First, Middle, Maiden Surname): Vesta Theresa Shank

19a. Informant's Name/Relationship (Type, Print): Marlene Weyant / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4036 Abingin Drive, Abingdon, MD 21009

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Park

Date: 12-18-03

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DME

29c. License number: D21809

29d. Date signed (Month, Day, Year): DEC 14, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GS PRABHU MD 2336 YORK RD TIMONIUM MD 21093.

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then 'natural', or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Weyant, William Francis

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar AMEND ITEM 23a_c&PII per phy g826 12/19/03 JH

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

2003 41140
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Anthony W. Zaiko, Sr.
2. Date of Death Month Day Year: DECEMBER 10, 2003
3. Time of Death: 12:15 PM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-24-0662
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 04/19/1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Kingsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11608 Stocksdale Road
10f. Zip Code: 21087
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Phillipines
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Trucking Industry

17. Father's Name (First, Middle, Last): Wesley Zaiko
18. Mother's Name (First, Middle, Maiden Surname): Agafia Kachan

19a. Informant's Name/Relationship (Type, Print): Theresa H. Zaiko (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11608 Stocksdale Road - Kingsville, MD 21087

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Trinity Russian Orth.
Date: 12/13/2003
20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: Heather Lassahn Chgocki
22. Name and Address of Facility: E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, MD 21087

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): ISCHEMIC ENTEROCOLITIS — Approximate Interval Between Onset and Death: 2DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. ADULT RESPIRATORY DISTRESS SYNDROME — WEEKS
Due to (or as a consequence of): MULTISYSTEM FAILURE — WEEKS
b. ADULT RESPIRATORY DISTRESS SYNDROME — WEEKS
Due to (or as a consequence of): CARDIOVASCULAR INSUFFIENCY — WEEKS
c. POSTOPERATIVE CARDIOPULMONARY INSUFFICIENCY — WEEKS
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MYOCARDIAL INFARCTION REMOTE MYOCARDIAL INFARCTION
ISCHEMIC ENTEROCOLITIS STATUS POST CHOLECYSTOTOMY
VASCULITIS OF GALLBLADDER

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Steven R Axe MD Pathologist
29c. License number: D34543
29d. Date signed (Month, Day, Year): 12-10-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN R. AXE, M.D. 7601 OSLER DRIVER, TOWSON, MARYLAND 21204

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

g34

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2003 41141

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LAWRENCE EDWARD ZIEWACZ
2. Date of Death (Month, Day, Year): December 16, 2003
3. Time of Death: 08:00 AM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 367-42-4420
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 60 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/23/1942
9. Birthplace (State or Foreign Country): MICHIGAN

Usual Residence of Decedent

10a. State: MI
10b. County: INGHAM
10c. City, Town or Location: EAST LANSING
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 684 WAYLAND STREET
10f. Zip Code: 48823
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PROFESSOR
16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): LAWRENCE J. ZIEWACZ
18. Mother's Name (First, Middle, Maiden Surname): CAROLINE DEDO

19a. Informant's Name/Relationship (Type, Print): ELIZABETH K. MURCH
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5924 BLAVERLY DRIVE, NEW ALBANY OH 43054

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EAST LAWN MEM. GARDENS
Date: 12/20/2003
20c. Location - City or Town, State: OKEMOS, MI

21. Signature of Funeral Service Licensee: Kelly Gregory Fink
KELLY GREGORY FINK #MO1148
22. Name and Address of Facility: FINK FUNERAL HOME, PA
426 CRAIN HWY., S, GLEN BURNIE, MD 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Pancreatic Cancer — Approximate Interval Between Onset and Death: 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Acute Renal Failure — 1 week
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature], Medical Doctor
29c. License number: Res - 000
29d. Date signed (Month, Day, Year): December 16, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy Sciallo, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland, 21287

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

James O. Burke, Sr.
UNK 03-375
CPM
03-7648

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amended 20a, 20b, 20c 12/9/03, LDB, DOR CO

# Certificate of Death

Reg. No. 2003 41142

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Oliver Burke, Sr.
2. Date of Death: Month November Day 29 Year 2003
3. Time of Death: 7:24 PM
4a. Facility Name (If not institution, give street and number): Fox Meadow Road
4b. City, Town, or Location of Death: Star
4c. County of Death: Queen Anne's

**Funeral Director**

5. Social Security Number: 214-42-9054
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 55 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 22, 1948
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Queen Anne's
10c. City, Town or Location: Queenstown
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 6311 - Main Street
10f. Zip Code: 21658
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Handyman
16b. Kind of Business/Industry: Private Business

17. Father's Name (First, Middle, Last): William Burke
18. Mother's Name (First, Middle, Maiden Surname): Constance Gibbs

19a. Informant's Name/Relationship (Type, Print): James O. Burke, JR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 91323 Eastham Court Crofton, Maryland 21114

20a. Method of Disposition: ~~1 ☑ Burial~~ 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mid-Shore Cremation ~~Bryans Cemetery~~
Date: 12/09/03
20c. Location - City or Town, State: Cambridge, MD ~~Grasonville, MD~~

21. Signature of Funeral Service Licensee: Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home, P.A. 510 Washington St. Cambridge, MD. 21613

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. multiple injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? XX Yes 2 ☐ No
26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year): 11-29-03
28b. Time of Injury: 7:24 P M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: Deceased driving car at high speed. Car left road.
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): ROAD
28f. Location (Street and Number or Rural Route Number, City or Town, State): Fox Meadow Rd, at 309

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 01, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 09 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41143

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Ruby | May | Bennett | December 7,2003 | 6:45A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 12573 Charles Street | La Plata | Charles |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 234-26-7037 | 1☐M 2☒F | 89 Yrs. | | | February 17,1914 | WV |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Charles | La Plata | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12573 Charles Street | 20646 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| N/A | | Cashier | Retail |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James C. Gregory | Effie Hamrick |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Martha Howe/Daughter | 12573 Charles St. La Plata,MD 20646 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | The Point Mountain Cem. | 12/13/03 | Webster Springs, WV |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Ward C. Echols M00945 | AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD 20646 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. INANITION (CACHEXIA)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DEMENTIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEVERE OSTEOPOROSIS

COPD

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D37467 | 12/8/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
F. Alex Leon,M.D. 3261 Old Washington Rd.,Suite 3010,Waldorf,MD20602

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 10 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41144

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Kui | Cheng | Dec 8, 2003 | 11:50 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Southern Maryland Hospital | Clinton | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex 1☐M 2☐F | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 107 46 6748 | XX | 84 Yrs. | | | Aug 1, 1919 | China |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Charles | Waldorf | 1☐Yes 2☒No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2305 Hawks Landing Court | 20601 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed XX 4☐Divorced | 1☐Yes 2☒No XX If Yes, Give Year or Dates: | 1☐Yes 2☒No XX Specify: | Specify: Asain |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8th | | Restaurant Cook | Peking Restaurant |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Chuong Queng | Chan Yi Mei |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ming Cheng (SON) | 2305 Hawks Landing Court, Waldorf, MD 20601 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial XX 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Lincoln Memorial Cemetery | Dec 23, 2003 | Suitland, Maryland |

21. Signature of Funeral Service Licensee: ▶ Kelvin P Trigg 101340

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandira Ferry Road, Clinton, Maryland 20735

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardio Respiratory arrest | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Atrial fibrillation, Hypertension | |
| | Due to (or as a consequence of): | |
| | c. Coronary heart disease | |
| | Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Type II Diabetes Mellitus
Chronic obstructive Heart disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Youngsik Moon M.D

29c. License number: D0917

29d. Date signed (Month, Day, Year): December 10 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Youngsik Moon, MD 24435 Mervell Dean Road, Hollywood, MD 20636

**State Registrar**

31. Date filed (Month, Day, Year): DEC 11 2003

32. Registrar's Signature: Steven A. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

12-8-03 @ 11:50 P.M

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Cheng Kui approved

B25

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41145

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| ARTHUR | EDWARD | COSGROVE | DEC. 1, 2003 | 9:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 818 UNIONTOWN RD. | WESTMINSTER | CARROLL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 172-30-7508 | [X] 1 M 2 F | 66 Yrs. | | | FEB.12,1937 | PENNSYLVANIA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | CARROLL | WESTMINSTER | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 818 UNIONTOWN RD. | 21158 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1960 1962 | 1 [ ] Yes 2 [X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | HEAVY EQUIPMENT OPERATOR | CITY OF BALTIMORE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| THOMAS L. COSGROVE | MARY LOUISE FAULX |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JUNE OWENS - SISTER-in-Law | 42 HILLSIDE CT.,WESTMINSTER, MD. 21157 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) | EVERGREEN MEM.GARDENS | 12/6/03 | FINKSBURG, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | FLETCHER FUNERAL HOME 254 E. MAIN ST.,WESTMINSTER, MD. 21157 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE MYOCARDIAL INFARCTION | IMMED |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

NON INSULIN DEPENDENT DIABETES MELLITUS

CARCINOMA OF LUNG

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No | 24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No |
|---|---|

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 [ ] Yes 2 [ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Vincent J Fiocco MD | D0 1663 | 12/4/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VINCENT J. FIOCCO JR 906 E WASHINGTON RD WESTMINSTER MD 21157

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 04 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

WJL 19+1VA

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41146

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Larry F. Colman | Dec. 2, 2003 | 4:45 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Dorchester General Hospital | Cambridge | Dorchester |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 497-34-0449 | 1☒M 2☐F | 65 Yrs. | | | July 26, 1938 | Missouri |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Dorchester | Hoopersville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1605 Steamboat Wharf Rd. | 21634 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Seafood Company Owner | Shellfish |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Oliver Colman | Lowella Foster |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Janet R. Colman/Wife | 1605 Steamboat Wharf Rd., Hoopersville, MD 21634 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | DorchesterMemPark | 12/5/2003 | Cambridge, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Curran-Bromwell | Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiac Failure | 1 Day |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): Hypotension/Shock | 1 Day |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D026040 | Dec. 8, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Craig Schaefer, 100 Bramble St., Cambridge, MD 21613

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41147

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dorothy Emily Chester

2. Date of Death Month Day Year: Dec. 02, 2003

3. Time of Death: 5:10 AM

4a. Facility Name (If not institution, give street and number): Dorchester General Hospital

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

**Funeral Director**

5. Social Security Number: 216-18-8011

6. Sex: 1☐ M 2☑ F

7. Age (in yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 04, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 700 Greenwood Avenue

10f. Zip Code: 21613

10g. Citizen of What Country? USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Production Line Worker

16b. Kind of Business/Industry: Seafood Industry

17. Father's Name (First, Middle, Last): Alfred Young

18. Mother's Name (First, Middle, Maiden Surname): Edna Chester

19a. Informant's Name/Relationship (Type, Print): Keita Bailey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 700 Greenwood Ave. Cambridge, MD. 21613

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cordtown Cemetery

Date: 12/6/03

20c. Location (City or Town, State): Cordtown, Maryland

21. Signature of Funeral Service Licensee: Janelle C. Henry

22. Name and Address of Facility: Henry Funeral Home, P.A. 510 Washington St Cambridge, MD. 21613

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cor Pulmonale

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pulmonary Hypertension

Due to (or as a consequence of):

c. Acute Renal Failure

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B Paltoo M.D

29c. License number: D0057040

29d. Date signed (Month, Day, Year): 12/02/2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRENDON PALTOO 105 AURORA ST. CAMBRIDGE, MD 21613

**State Registrar**

31. Date filed (Month, Day, Year): DEC 05 2003

32. Registrar's Signature: Jeanne L. Spicer

DHMH 17 Rev 1/2001

ORIGINAL

Chester, Dorothy

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

03-7964
B.K.S
CAROL ANN CHADWICK

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **unpend Item#23a,27,28a-f,Per ME,G828,2/27/04eg**

# Certificate of Death

Reg. No. 2003 41148

2831

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Carol Ann Chadwick | DEC. 10, 2003 | 0820 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 7317 ROSELYN LANE | CLINTON | PRINCE GEORGES |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219 86 8070 | 1☐M 2☒F XX | 43 Yrs. | | | Nov 7, 1960 | North Carolina |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George | Clinton | 1☐Yes 2☒No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7317 Roselyn Lane | 20735 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married XX 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No XX If Yes, Give Year or Dates: | 1☐Yes 2☐No XX Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | Secretary | Private Industry |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John S. Chadwick | Dolores King |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John Chadwick (father) | 7317 Roselyn Lane, Clinton, Maryland 20735 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial XX 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Resurrection Cemetery | Dec 15, 2003 | Clinton, Maryland |

21. Signature of Funeral Service Licensee ▶ M005442

22. Name and Address of Facility Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. **Clonazepam Intoxication**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day, Year) found 12/10/03

28b. Time of Injury found 8:00 a M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found in residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 7317 Roselyn Lane,Clinton,MD 20735

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Theodore M. Kijewski | O.C.M.E | DEC. 11, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. KIJEWSKI 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ James B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

EDWARD LEE DAGGETT
03-08033
RKD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2003 41149
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EDWARD LEE DAGGETT
2. Date of Death Month Day Year: DECEMBER 13, 2003
3. Time of Death: 3:25P. M
4a. Facility Name (If not institution, give street and number): SHOCK TRAUMA CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: 216-12-1203
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 26 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Kent
10c. City, Town or Location: Betterton
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 20 Ericsson Ave.
10f. Zip Code: 21610
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Guard
16b. Kind of Business/Industry: Chemical Company

17. Father's Name (First, Middle, Last): Wilbur Daggett
18. Mother's Name (First, Middle, Maiden Surname): Mary Louise Lehmann

19a. Informant's Name/Relationship (Type, Print): Charles Daggett (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Wheeler Ave. Betterton, MD. 21610

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Kent Cremation
Date: 12/19/03
20c. Location - City or Town, State: Smyrna, DE.

21. Signature of Funeral Service Licensee: [signature] M00510
22. Name and Address of Facility: Galena Funeral Home of Stephen L Schaech, 118 West Cross St. Galena, MD. 21635

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Contact gunshot wound to head

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

tF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): Found 12/13/03
28b. Time of Injury: Found 1155 A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject shot self
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): At home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 20 Ericsson Ave, Betterton, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.E.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 14, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ZACHARIAH AL 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41150

Mary C. Duckett

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Mary | Catherine | Duckett | DECEMBER 1 2003 | 6:00AM |

| 4a Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| CIVISTA MEDICAL CENTER | LAPLATA | CHARLES |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-76-5296 | 1☐ M 2☒ F | 62 Yrs. | | | November 2,1941 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Charles | Waldorf | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12145 Ell Lane Apt. 30 | 20602 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No *Specify:* | *Specify:* Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Domestic |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Howard O Simms | Mary F Dotson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Cynthia Duckett/Daughter | 2110 Brooks Dr. #304 Forestville,Maryland 20747 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | St.Thomas Ch. Cem | 12/8/03 | Baden,Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Odessa Offer MO1323 | Adams Funeral Home P.A. Aquasco,Maryland |

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End-stage renal disease

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | DH0058095 | 12/01/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TONYA L HARDY MD 11345 PEMBROOKE SQUARE SUITE 104 WALDORF MD 20603

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DB2

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 10 2003 | [signature] |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41151

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Audrey French Fletcher

2. Date of Death: Month December Day 1 Year 2003

3. Time of Death: 18:50 M

4a. Facility Name (If not institution, give street and number): Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 216-12-2386

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 6, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Sharptown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 600 Railway Street

10f. Zip Code: 21861

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager

16b. Kind of Business/Industry: Engineering and Architect

17. Father's Name (First, Middle, Last): Otis Thomas Butterworth

18. Mother's Name (First, Middle, Maiden Surname): Radie Roberta McAnally

19a. Informant's Name/Relationship (Type, Print): James R. Fletcher/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 526, Washington Grove, Maryland 20880

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Mem. Gard.

Date: 12/04/2003

20c. Location - City or Town, State: Hebron, Maryland

21. Signature of Funeral Service Licensee: Leonard D. Zeller

22. Name and Address of Facility: Zeller Funeral Home, P. O. Box 3171, Salisbury, Maryland 21802

**Physician /Medical Examiner**

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Amyotrophic Lateral Sclerosis — 3 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice House

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D35635

29d. Date signed (Month, Day, Year): December 2, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Kaplan, M.D., 6001 Muncaster Mill Road, Rockville, MD 20855

**State Registrar**

31. Date filed (Month, Day, Year): DEC 04 2003

32. Registrar's Signature

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41152

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Tayla Hopkins
2. Date of Death: Month December Day 4 Year 2003
3. Time of Death: 2101 M
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE City
4c. County of Death:

**Funeral Director**

5. Social Security Number: None
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months / Days: 1
If Under 24 Hrs.: Hours / Min.:
8. Date of Birth (Month, Day, Year): December 3, 2003
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Indian Head
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 15 Shelton Court
10f. Zip Code: 20640
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Baby
16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Kevin Wade Hagy, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Amanda Allison Hopkins

19a. Informant's Name/Relationship (Type, Print): Amanda Allison Hopkins Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 Shelton Court, Indian Head, Md.20640

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Funeral Service
Date: December 10, 2003
20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: M00668
22. Name and Address of Facility: Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory distress syndrome — Approximate Interval Between Onset and Death: 24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Sepsis — 24 hours
Due to (or as a consequence of):
c. Poor perfusion — 24 hours
Due to (or as a consequence of):
d. Prematurity — 24 hours

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
intrauterine growth retardation
Prolonged premature rupture of membranes

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): December 4, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
4716 DORSEY HALL DRIVE APARTMENT 502, ELLICOTT CITY, MARYLAND 21042

**State Registrar**

31. Date filed (Month, Day, Year): DEC 11 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41153

HARRIS, ALBERT

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Albert Clinton Harris, Jr. | December 8, 2003 | 4:36 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Carroll Hospital Center | Westminster | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-03-7367 | 1☒ M 2☐ F | 89 Yrs. | | | Feb 20, 1914 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Carroll | Manchester | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5316 Hoffmanville Road | 21102 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Plumber | State of Maryland |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Albert C. Harris, Sr. | Edna Bosley |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gail Willin, daughter | 1100 Metfield Road, Towson, MD 21286 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Evergreen Memorial | 12/11/2003 | Finksburg, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Steven W Eline M-0723 | Eline Funeral Home 934 South Main St, Hampstead, MD 21074 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| a. | Pneumonia | 4 day |
| | Due to (or as a consequence of): | |
| b. | Ischmic Heart Disease | 25yr |
| | Due to (or as a consequence of): | |
| c. | Advanced Age | 89yr |
| | Due to (or as a consequence of): | |
| d. | COPD | 25yr |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ John W Middleton MD | D25443 | 12/8/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John W Middleton 188 Poole Road, Westminster MD 21157

WJZ 6 tl VA

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | ▶ Rebecca A Speicher |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41154

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Bertha Trice Harper | December 4, 2003 | 2:40PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 103 Broad Street | Hurlock | Dorchester |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 548-30-5075 | 1☐ M 2☒ F | 91 Yrs. | | | Dec. 24, 1911 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Dorchester | Hurlock | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 103 Broad Street | 21643 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Postal Clerk | US Postal Service |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lloyd Nicholas Trice | Beulah Bradley |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Charlotte T. Smith/Sister | 5834 Thompsontown Road, East New Market, MD 21631 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Unity Washington Cem. | 12/07/2003 | Hurlock, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Donald L. Zeller | Zeller Funeral Home, P. O. Box 207, 106 Main Street, East New Market, MD 21631 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. HYPOXIA | MINUTES |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. PNEUMONIA | DAY |
| | Due to (or as a consequence of): | |
| | c. LUNG CANCER | YEARS |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Paul M. Reinbold ATTENDING MD PHYSICIAN | D0053094 | 12-5-2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul M. Reinbold, M.D., 321 Bloomingdale Avenue, Federalsburg, MD 21632

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | Jeanne B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41155

Heath, Lela G.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Lela Gertrude Heath | Dec. 6, 2003 | 3:20 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Civista Medical Center | LaPlata, MD | Charles |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 340-14-3084 | 1☐ M 2☒ F | 81 Yrs. | | | Mar. 1, 1922 | Ohio |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Charles | La Plata | 1☒ Yes 2☐ No |

| 10e. Street end Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1 Hickory Lane Apt. #514 | 20646 | U.S.A. |

| 11. Maritel Status | 12. Wes Decedent Ever in U,S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Dispatcher | Oil |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| James H. Pepper | Lena Edrungton Pepper |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ronald Heath, Sr./ Son | 7100 Annapolis Woods Road La Plata, MD 20646 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify) | Trinity Memorial | 12/10/03 | Waldorf, Maryland |

21. Signature of Funeral Service Licensee M00945 — Daniel C. Echols

22. Name and Address of Facility
Arehart-Echols Funeral Home, P.A.
P.O. 567 La Plata, Maryland 20646

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 4 yrs.

Due to (or as a consequence of):
b. RENAL INSUFFICIENCY 1 wk

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. CUTANEOUS ANAPLASTIC CARCINOMA 1 yrs.

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Wes an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D-20629 | 12/7/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George H. Wathen, MD 11345 Pembrooke Square, #103 Waldorf, MD 20603

**State Registrar**

| 31. Dete filed (Month, Day, Year) | 32. Registrer's Signature |
|---|---|
| DEC 10 2003 | |

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attanding Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attanding physician and completely filled in by the funeral director, paga 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41156

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| OZITE | INGERSOLL | December 7, 2003 | 1645 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 6106 South Point Rd. | Berlin | Worcester |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577-46-0127 | 1☐M 2☒F | 69 Yrs. | | | 2-17-34 | KY |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Worcester | Berlin | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6106 South Point Rd. | 21811 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Waitress | Restaurant |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lando Gooselin | Annie Perry |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John Ingersoll Son | 6106 South Point Rd. Berlin, Md., 21811 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Trinity Mem. Gdns. | 12-12-03 | Charles Co., Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Ullrich Funeral Home Berlin, Md. |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Lung Cancer | 7 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature], MD | D26278 | 12-8-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID CONNELL MD 145 E Carroll St. Salisbury, MD 21801

ET 1

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended 1- For State Registrar item# 20b, 12/10/2003, E.T. **Certificate of Death** WCHD Reg. No. 2003 41157

JACOBS CHARLES DOB 2010 213-30-0424 12-7-34

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| CHARLES A. JACOBS | | | December 7, 2003 | 2010 M |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | |
| Atlantic General Hospital | Berlin | | Worcester | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-30-0424 | 1 ☒ M 2 ☐ F | 69 Yrs. | | | 7-29-34 | Md. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Worcester | Ocean Pines | 1 ☒ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 115b Windjammer Road | 21811 | |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Civil Engineer | Public Transportatio |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Albert Jacobs | Elizabeth Cunabaugh |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Estelle Wynn Fiancee | 115 Windjammer Rd. Ocean Pines, Md., 21811 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | High View Mem. Park ~~Highview Mem. Park~~ | 12/13/2003 | Fallston, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Ullrich Funeral Home Berlin, Md. |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial infarct

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)
Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D0060535 | December 7, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nadio Angov, MD 9733 Healthway Drive, Berlin, MD 21811

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 10 2003 | [signature] |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

E.T

DHMH 17 Rev 1/2001

ORIGINAL

CPM
03-07896
ANTOINETTE KUSHNER

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41158

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ANTONETTE KUSHNER | December 08, 2003 | 18:42 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 811 Fairfield Avenue | Westminster | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 209-26-2669 | 1☐M 2☐F XX | 88 Yrs. | | | | | DECEMBER 30,1914 | PENNSYLVANIA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | CARROLL | WESTMINSTER | 1☐Yes 2☐No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 815 WASHINGTON ROAD | 21157 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3XXWidowed 4☐Divorced | 1☐Yes 2XXNo If Yes, Give Year or Dates: | 1☐Yes XXNo Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | HOMEMAKER | DOMESTIC |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOSEPH NEVADUNSKIS | ANTONETTE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| FRANCIS KUSHNER/SON | 815 WASHINGTON ROAD, WESTMINSTER, MD 21157 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2XXCremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | CARROLL CREMATION | 12/10/2003 | HAMPSTEAD, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Justin R. Durboraw | MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, MD 21157 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Atherosclerotic Cardiovascular disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2XNo 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4XUnknown | 1XYes 2☐No | 1XYes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| XXYes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6XOther (Specify) SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1XNatural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Zachiller M.D. | O.C.M.E. | December 09, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ZACHILLER M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | Jeanne M Spratt |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

WJL
6

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41159

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Stuart Olan Leister | December 6, 2003 | 12:15 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 701 N. Houcksville Road | Hampstead | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-42-1423 | 1☒M 2☐F | 71 Yrs. | | | Sep 19, 1932 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Carroll | Hampstead | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 701 N. Houcksville Road | 21074 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Dairy & Grain Farmer | Farming |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Sterling Jacob Leister | Addie Virginia Cullison |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia A. Leister, wife | 701 N. Houcksville Rd, Hampstead, MD 21074 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Hampstead Cemetery | 12/09/2003 | Hampstead, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Steven E Kline MD723 | Eline Funeral Home 934 South Main St, Hampstead, MD 21074 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. D. Liver Sarcoma — Due to (or as a consequence of): — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No |
|---|---|

| 25. Was case referred to medical examiner? 1☐Yes 2☒No | 26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |
|---|---|

| 27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D33165 | 12/8/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Strother MD 2111 Hanover Pike Hampstead MD 21074

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41160

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Irwin Lowe | December 7 2003 | 9:45 a. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2350 Hoopers Island Road | Fishing Creek | Dorchester |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 267-28-2847 | 1☒M 2☐F | 75 Yrs. | | | April 7, 1928 | New York |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Dorchester | Fishing Creek | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2350 Hoopers Island Road | 21634 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1945-50 | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | 2 | shop owner | antiques |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Emile Lowe | Celia Kaye |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patsy Lowe wife | 2350 Hoopers Island Rd., Fishing Creek, MD 21634 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Salisbury Crematory | 12/9/03 | Salisbury, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Brian K. Burton | Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pancreatic adenocarcinoma | 4 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| M.D. | D50804 | 12-8-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark Malkus, M.D. 408 Byrn Street Cambridge, MD 21613

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

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**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DOS
03-8060
Aaron A. Martin

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41161

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Aaron Albertus Martin | December 15 2003 | 317 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington CountyHospital | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-92-3603 | 1 [X] M 2 [ ] F | 27 Yrs. | | | November 28, 1976 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Allegany | Lonaconing | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 20320 Sunlight Drive S. W. | 21539 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Waiter | Restaurant |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Allen Martin | Mary Elaine Boore |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Elaine Martin-Mother | 20320 Sunlight Drive S.W., Lonaconing, Maryland 21539 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Sunset Memorial Park | December 18, 2003 | Cumberland, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Jon E McKee | Eichhorn-McKenzie Funeral Home P.A. 8 E. Main St.,Lonaconing,Md.21539 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Head injuries | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [X] Yes 2 [ ] No | 1 [X] Yes 2 [ ] No |

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 12-15-03 | 3:00 A M | 1 [ ] Yes 2 [X] No | Deceased driving → crashed, deceased ejected |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) road | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) WBI-70 at 14 mile marker, MD. |

29a. Certifier (Check only one) 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | OCME | December 15 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41162

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Elizabeth Thomas Moran

2. Date of Death Month Day Year: December 10 2003

3. Time of Death: 0149 A M

4a. Facility Name (If not institution, give street and number): Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

**Funeral Director**

5. Social Security Number: 195-14-1729

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 1, 1925

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5 Reed Hartnett Street

10f. Zip Code: 21921

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self-Employed Accountant

16b. Kind of Business/Industry: Accounting

17. Father's Name (First, Middle, Last): James Thomas

18. Mother's Name (First, Middle, Maiden Surname): Ellen Palmer

19a. Informant's Name/Relationship (Type, Print): Elizabeth T. Moran/Self

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Reed Hartnett Street, Elkton, Maryland 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gilpin Manor Memorial Park

Date: December 13, 2003

20c. Location - City or Town, State: Elkton, Maryland

21. Signature of Funeral Service Licensee: Daniel S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE — 1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CONGESTIVE HEART FAILURE — UNKNOWN

Due to (or as a consequence of):

c. ACUTE [illegible] INFARCTION — UNKNOWN

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Raulam M.D.

29c. License number: D 0058392

29d. Date signed (Month, Day, Year): DECEMBER 10, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SANDEEP GAUTAM, UNION HOSPITAL, ELKTON, MD 21921

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature: Jeanne G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other-traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41163

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Stella | Myers | Dec 7, 2003 | 4:50 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Millennium Health & Rehabilitation Center | Fort Washington | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 004 01 5996 | 1☐M 2☐F XX | 91 Yrs. | | | May 13, 1912 | Maine |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George's | Temple Hills | 1☐Yes 2☐No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4025 28th Ave | 20748 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed XX 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: XX | 1☐Yes 2☐No Specify: XX | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | Housewife | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frank H. Perkins | Edna Daisy Phillips |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Judith Myers (Daughter) | 4025 28th Ave, Temple Hills, MD 20748 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial XX 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Maryland Veterans Cemetery | Dec 12, 2003 | Cheltenham, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Louis L. Grant M00257 | Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D-18545 | DECEMBER 9, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P. WISOTZKEY M.D. 12070 OLD LINE CENTER WALDORF, Md. 20602

DB ID

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 11 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41164

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Herman Vernon Myers
2. Date of Death: Month 12 Day 3 Year 2003
3. Time of Death: 12:10 PM
4a. Facility Name (If not institution, give street and number): Carroll Hospital Center
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 219-22-6187
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 29 1923
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 422 Ridge Road
10f. Zip Code: 21157
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary-Treasurer
16b. Kind of Business/Industry: Teamsters Local #557

17. Father's Name (First, Middle, Last): Vernon Myers
18. Mother's Name (First, Middle, Maiden Surname): Delores Emerick

19a. Informant's Name/Relationship (Type, Print): Mary A. Myers/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 422 Ridge Road Westminster, MD 21157

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation, Inc
Date: 12/08/2003
20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Pritts Funeral Home and Chapel, Inc. 412 Washington Road Westminster, MD 21157

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. ASCVD
c.
d.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death:

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: MD 050410
29d. Date signed (Month, Day, Year): 12/3/2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Kerr MD Emerg Physician Carroll Hospital Ctr. 200 Memorial

**State Registrar**

31. Date filed (Month, Day, Year): DEC 08 2003
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended Item 5 per F.D. 12/18/2003 Carroll County, wjl

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41165

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Carol Hartman Marshall | December 5, 2003 | 1:20 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Casey House | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| ~~214-34-4444~~ ~~213-43-4444~~ | 1☐ M 2☒ F | 66 Yrs. | | | Jan 2, 1937 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Howard | Elkridge | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6718 Ducketts Lane | 21075 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Manager | State Use Industries |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William A. Hartman | Ruth Bayrle |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Douglas R. Marshall, son | 3701 N. Kensington St, Arlington, VA 22207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Carroll Cremations | 12/08/2003 | Hampstead, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Steven W Eline M00723 | Eline Funeral Home 934 South Main St, Hampstead, MD 21074 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Lung Cancer | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D41218 | 12/05/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Charles Harrison, 6001 Muncaster Mill Road, Rockville, MD 20855

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 15

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41166

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Joseph Francis Murphy | Dec. 7, 2003 | 9:25 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Charlotte Hall Veterans Home | Charlotte Hall | St. Mary's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-22-6778 | 1 [X] M 2 [ ] F | 80 Yrs. | | | July 2, 1923 | Maryland |

Usuet Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Charles | Hugesville | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6545 Fairfax Ct. | 20637 | U S A |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1963 1968 | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Chief Boswains Mate | U.S. Navy |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Edward T. Murphy | Mary Ann Murphy |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Judith A. Welch/daughter | 6545 Fairfax CT., Hughesville, MD 20637 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | church ST. Mary's Catholic cemetery | Dec. 11, 2003 | Bryantown, MD |

21. Signature of Funeral Service Licensee: John B. [illegible]

22. Name and Address of Facility: Brinsfield-Echols F.H., P.A. P.O. Box 128, Charlotte Hall, MD 20622

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ADVANCED DEMENTIA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEPRESSION, MYELOFIBROSIS, SEIZURES
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
PEPTIC ULCER DISEASE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [X] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D50963 | 12/08/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FULTON LUKBAN, MD, CMVH, CHARLOTTE HALL, MD

MP 54 IVA

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 10 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41167

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LEONARD F. McGUIRE
2. Date of Death (Month, Day, Year): December 6, 2003
3. Time of Death: 8:10 AM
4a. Facility Name (If not institution, give street and number): 2501 Philadelphia Ave.
4b. City, Town, or Location of Death: Ocean City
4c. County of Death: Worcester

**Funeral Director**

5. Social Security Number: 200 40 9219
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 51 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 28, 1952
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Worcester
10c. City, Town or Location: Ocean City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2501 Philadelphia Ave.
10f. Zip Code: 21842
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Motel Manager
16b. Kind of Business/Industry: Motel Industry

17. Father's Name (First, Middle, Last): Leonard S. McGuire
18. Mother's Name (First, Middle, Maiden Surname): Mary Harrison

19a. Informant's Name/Relationship (Type, Print): Leonard S. McGuire
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 217 Anthony St. Harrison City, PA 15636

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Restland Mem. Park
Date: 12/12/03
20c. Location - City or Town, State: Monroeville, PA

21. Signature of Funeral Service Licensee: W. Reid Burbage
22. Name and Address of Facility: 108 William St. The Burbage Funeral Home Berlin, MD 21811

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CORONARY Artery Disease

Due to (or as a consequence of):
b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Diabetes Mellitus

Due to (or as a consequence of):
d. Hyperlipidemia

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D0055906
29d. Date signed (Month, Day, Year): 12/7/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LUCY VAN VOORHEES, 314 Franklin Ave., Berlin, MD 21811

C.H. 10

**State Registrar**

31. Date filed (Month, Day, Year): DEC 08 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41168

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Clarence Franklin Palmer, JR. | December 7, 2003 | 0820 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Easton Memorial Hospital | Easton | Talbot |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-14-2700 | 1☑ M 2☐ F | 81 Yrs. | | | April 09, 1922 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Talbot | Wittman | 1☑ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 22381 Cooper Road | 21676 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced | 1☑ Yes 2☐ No If Yes, Give Year or Dates: 1942 1946 | 1☐ Yes 2☑ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Janitor | Resin Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Clarence Palmer, SR. | Laura Olivia Cooper |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ethel M. Palmer | 22381-Cooper Road Wittman, MD. 21676 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Charles Thomas Park | 12/13/03 | St. Michaels, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Janelle C. Henry | Henry Funeral Home, P.A. 510 Washington St. Cambridge, MD. 21613 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | 1° |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Coronary Artery Disease | 10 years |
| | c. Due to (or as a consequence of): Diabetes Mellitus Type 2 | 30 years |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Chronic Renal Failure
Hyperlipidemia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☑ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D47492 | 12/8/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jeffrey T. Denton, M.D., 555 Cynwood Drive, Easton, MD 21601

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

Clarence Palmer
**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41169

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Marianna Rodgers | December 10 2003 | 1:30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 173-58-0938 | 1☐M 2☒F | 40 Yrs. | | | 11-19-63 | Gettysburg, Pa. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Pa. | Adams County | Abbottstown | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 102 Protectory Road | 17301 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Chief Clerk | PennDOT |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Robert W. Martin | Marianna Olivieri |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Daniel L. Rodgers/husband | 102 Protectory Rd. Abbottstown, Pa. 17301 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Evergreen Cemetery | 12-13-03 | Gettysburg, Pa. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Davis L. Davis | Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Middle Cerebral Artery and Anterior Cerebral Artery Stroke | 7 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Cerebral Herniation | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☒Yes 2☐No 9☐Unknown | 1☐Live birth 2☒Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 11-30-03 |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ MD | P16589 | December 10 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sangjin Oh 22 South Greene Street Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41170

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Mary K. Russell | December 5, 2003 | 8:40P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Ruxton Health & Rehab. Center | Pikesville | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 415-36-8385 | 1☐M 2☒F | 76 Yrs. | | | June 14, 1927 | Limestone, Ten |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4030 Hickory Ave. | 21211 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Clerk | Retail jewelry |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Gus Brodrick Hylton | Helen Chain |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Freddie E. Yelton - son | 4030 Hickory Ave. Baltimore, MD 21211 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Louisville Bible Church Cem. | 12/09/03 | Gamber, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Justin R. Durboraw M01191 | Myers-Durboraw Funeral Home, P.A. 91 Willis Street Westminster, MD 21157 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. END STAGE PARKINSONS | 3 WEEKS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Deborah I Pierce | H45931 | December 8, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Deborah I Pierce 7220 Park Heights Avenue Baltimore MD 21208

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 4

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41171

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOAN SANDS

2. Date of Death: Month 12 Day 14 Year 03

3. Time of Death: 6:30 a M

4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 215 34 2638

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months ____ Days ____ If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): JULY 13 1936

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FROSTBURG

10d. Inside City Limits: ☒ 1 Yes 2 ☐ No

10e. Street and Number: 152 EAST MAIN STREET

10f. Zip Code: 21532

10g. Citizen of What Country? U.S.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): +1

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNER

16b. Kind of Business/Industry: BAR

17. Father's Name (First, Middle, Last): KENNETH KREILING

18. Mother's Name (First, Middle, Maiden Surname): LILLIAN DUGAN

19a. Informant's Name/Relationship (Type, Print): PATRICIA BRETT / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6810 CHESTNUT STREET, UPPER DARBY, PA 19082

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): THE CUMBERLAND CREMATORY Date: 12/22/03

20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Marilou M. Sowers

22. Name and Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN STREET FROSTBURG, MD 21532

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Gastrointestinal Bleed — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic Renal Cell Carcinoma — 12 months

Due to (or as a consequence of):

c. ____

Due to (or as a consequence of):

d. ____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Uterine Carcinoma

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas E Chappell

29c. License number: D 35135

29d. Date signed (Month, Day, Year): 12/15/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas Evan Chappell MD 912 Solon Dr Cumberland MD

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41172

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| JAMES L. SMALLWOOD | DECEMBER 9, 2003 | 9:15 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 12610 SHILOH CHURCH ROAD | NEWBURG | CHARLES |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-46-6616 | 1☐M 2☐F X | 75 Yrs. | | | FEBRUARY 25,1928 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | CHARLES | NEWBURG | 1☐Yes 2☐No X |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12610 SHILOH CHURCH ROAD | 20664 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 0 | | GROUNDSKEEPER | HORTICULTURE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JAMES SMALLWOOD | MAGEDLINE PROCTOR |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| FRANCIS PROCTOR / BROTHER | 312 NORTH CALHOUN STREET, BALTIMORE, MARYLAND 21223 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | HOLY GHOST CHURCH CEMETERY | DEC. 15, 2003 | ISSUE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| LYDIA C. THORNTON JOHNSON MO0583 | THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ADENOCARCINOMA of STOMACH — x MONTH

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic Cancer of Stomach — x MONTH

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D20629 | 12/11/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GREGORY W. WARD M.D. WALDORF, MD 20603

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 11 2003 | |

**State Registrar**

BB2

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attanding Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41173

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Velma | M | Starling | DECEMBER 1, 2003 | 08:36 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| MALCOM GROW MEDICAL CENTER | CAMP SPRINGS | PRINCE GEORGE'S |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577-32-8890 | 1☐ M 2☒ F | 76 Yrs. | | | August 6,1927 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince Georges | Forestville | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2513 Ritchie Road | 20747 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Secretary | Federal Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Mathias Simmons | Ethel Brown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Thomas Gray/Son | 10913 Phillips Drive Upper Marlboro,Maryland 20772 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Resurrection Cemetery | 12/9/03 | Clinton,Maryland |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| ▶ Odessa Offer | MO1323 | Adams Funeral Home P.A. Aquasco,Maryland |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. UNCONTROLLED HYPERTENSION | 1 MONTH |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Richard F. Garri | NE 21250 | DECEMBER 1, 2003 |

| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | |
|---|---|
| RICHARD F. GARRI, MAJ, USAF, MD | 89 MDG/ 1050 W. PERIMETER RD. ANDREWS AFB, MD 20762-6600 |

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 10 2003 | ▶ Eileen M. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41174

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Temple

2. Date of Death Month Day Year: December 14, 2003

3. Time of Death: 11:58AM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 074-22-0217

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 27, 1923

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 5600 Genesis Lane

10f. Zip Code: 21703

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Crowe

18. Mother's Name (First, Middle, Maiden Surname): Meta Graham

19a. Informant's Name/Relationship (Type, Print): Mr. Robert N. Brown, Jr., son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7301 Brookside Dr., Frederick, MD 21702

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery

Date: Dec. 19, 2003

20c. Location - City or Town, State: Frederick, MD

21. Signature of Funeral Service Licensee: ▶ Richard E. Troy M00255

22. Name and Address of Facility: Keeney and Basford PA Funeral Home, 106 East Church Street, Frederick, MD 21701

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — 2 WKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. COPD — 10 YRS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARTIAL BOWEL OBSTRUCTION, HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Donelson MD

29c. License number: D21936

29d. Date signed (Month, Day, Year): 12/15/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. DONELSON MD 65C THOMAS JOHNSON DR FREDERICK MD 21702

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature: ▶ Regina B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41175

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| HOMER | FRANKIE | TYLER | DECEMBER 12 2003 | 2008 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA Regional Medical CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-66-0767 | 1 ☒ M 2 ☐ F | 58 Yrs. | | | April 2, 1945 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Somerset | Marion Station | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6599 Charles Cannon Road | 21838 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Vietnam Era | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Owner | Seafood Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Homer Tyler | Wanda Marie Middleton |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gayle Windsor Tyler (Wife) | 6599 Charles Cannon Road - Marion Station, MD 21838 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | St. Paul's Cemetery | Dec. 16, 2003 | Marion Station, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Mary Beth Bradshaw-Pruitt<br>Mary Beth Bradshaw-Pruitt | Bradshaw & Sons Funeral Home<br>306 W. Main Street - Crisfield, Maryland 21817 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Homer F. Tyler 212-66-0767

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Carcinoma of the Lung — Due to (or as a consequence of): — days — months

c. — Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| M.D. | 20441 | 12/15/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. L. RAFFETTO M.D. 100 E. CARROLL ST. SALISBURY MD

5

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | Donna G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41176

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Kenneth Charles Taber | December 10 2003 | 2014 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Union Hospital | Elkton | Cecil |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 064-30-4715 | 1☒M 2☐F | 66 Yrs. | | | May 25, 1937 | New York |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Cecil | Elkton | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12 Megan Circle | 21921 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Metallurgical Engineer | Testing Research |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Howard K. Taber | Gertrude Chappel |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lucinda J. Taber/Wife | 12 Megan Circle, Elkton, Maryland 21921 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Sharps Cemetery | December 15, 2003 | Fair Hill, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Donald S. Hicks | Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Benylliosis
Hypertension

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☑Unknown | 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☑Yes 2☐No | Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Laura Ellis MD | D58313 | 12/10/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Laura Ellis, M.D., 106 Bow Street, Elkton, Maryland 21921

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41177

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| John | Lynn | Thoma | December 3 2003 | 2345 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Southern Maryland Hospital | Clinton | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 481-50-4029 | XX M 2☐ F | 62 Yrs. | | | Jan. 15, 1941 | Iowa |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George's | Upper Marlboro | 1☐ Yes 2XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12705 Midstock Lane | 20772 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2X Married 3☐ Widowed 4☐ Divorced | 1X Yes 2☐ No If Yes, Give Year or Dates: 1964-1985 | 1☐ Yes 2X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4 | USAir Force Ret. | U.S. Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lewis G. Thoma | Alice A. Culver |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gerald Thoma (Brother) | 1704 Lee Road Ft. Washington, Maryland 20744 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1X Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Maryland Veterans Cemetery | Dec. 12, 2003 | Cheltenham, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Mut Old Pah 100153 | Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Hypertensive Heart Disease

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Salvador Sylvester DO | H00559?? | December 10, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 11 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**Division of Vital Records, P.O. Box 68760,**

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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

MEGAN M TAYLOR
03-7733
DAP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41178

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Megan Marie Taylor | DECEMBER 2,2003 | 4:38p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1820 HAMPSTEAD MEXICO ROAD | WESTMINSTER | CARROLL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-31-7944 | 1☐ M 2☒ F | 17 Yrs. | | | Oct 24 1986 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Carroll | Westminster | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4220 Trump Road | 21158 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Student | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Dennis W. Taylor | Vicky Heagy |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| M/M Dennis Taylor/parents | 4220 Trump Road Westminster, MD 21158 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Carroll Cremation, Inc | 12/8/2003 | Hampstead, MD |

21. Signature of Funeral Service Licensee: ▶ R. Scott Pritts

22. Name and Address of Facility: Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☒ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒ Yes 2☐ No | 1☒ Yes 2☐ No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? |
|---|---|---|
| 12-2-03 | 4:33P M | 1☐ Yes 2☒ No |

28d. Describe how injury occurred: Passenger of motor vehicle that collided with another motor vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Road

28f. Location (Street and Number or Rural Route Number, City or Town, State): 1820 Hampstead Mexico Rd, Westminster MD

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Ling Li. M.D | OCME | DECEMBER 3,2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ling Li. M.D 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 0 8 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

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4
CRW

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41179

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Eva Ruth Travers
2. Date of Death (Month, Day, Year): December 2, 2003
3. Time of Death: 4:20 P M
4a. Facility Name (If not institution, give street and number): 6125 Fooks Mill Road
4b. City, Town, or Location of Death: Rhodesdale
4c. County of Death: Dorchester

**Funeral Director**

5. Social Security Number: 220-01-8878
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 23, 1919
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Rhodesdale
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6125 Fooks Mill Road
10f. Zip Code: 21659
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): sewing machine operator
16b. Kind of Business/Industry: garment mfg.

17. Father's Name (First, Middle, Last): Baynard Wheatley Hurley
18. Mother's Name (First, Middle, Maiden Surname): Nora Rebecca Hurley

19a. Informant's Name/Relationship (Type, Print): Lee L. Travers III son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6125 Fooks Mill Rd., Rhodesdale, MD 21659

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dorchester Memorial Park
Date: 12/6/03
20c. Location - City or Town, State: Cambridge, MD

21. Signature of Funeral Service Licensee: Brian K. Butler
22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Advance Dementia — year

Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Arteriosclerotic Heart disease — year
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D 47924
29d. Date signed (Month, Day, Year): 12-3-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NOMAN THANWY 300 AURORA ST CAMBRIDGE MD 21613

**State Registrar**

31. Date filed (Month, Day, Year): DEC 05 2003
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41180

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Maurice Ellsworth Turner
2. Data of Death Month Day Yaar: Dec. 03, 2003
3. Time of Death: 4:05AM
4a Facility Nama (If not institution, giva street and number): Ruxton Health Center
4b. City, Town, or Location of Death: Denton
4c. County of Death: Caroline

**Funeral Director**

5. Social Sacurity Number: 215-20-1471
6. Sax: 1☑M 2☐F
7. Aga (In yrs. last birthday): 77 Yrs.
If Undar 1 Yaar: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): Dec. 08, 1925
9. Birthplaca (Stata or Foraign Country): Maryland

Usual Residence of Decedent

10a. Stata: MD
10b. County: Queen Anne's
10c. City, Town or Location: Wye Mills
10d. Insida City Limits: 1☐Yas 2☑No
10e. Street and Number: P.O. Box 45 - Rusty Acres Lane
10f. Zip Code: 21679
10g. Citizen of What Country: USA

11. Marital Status: 1☐Naver Married 2☑Married 3☐Widowed 4☐Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐Yas 2☑No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yes 2☑No Specify:
14. Race - Amarican Indian, Black, Whita, etc. Specify: Black

15. Decedent's Education (Specify only highest grada complatad): Elamantary/Secondary (0-12): 6; Collega (1-4or 5+):
16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Transportation

17. Fathar's Nama (First, Middla, Last): Martin Turner
18. Mothar's Nama (First, Middla, Maiden Sumame): Marie Stewart

19a. Informant's Name/Ralationship (Type, Print): Mary Turner
19b. Mailing Address (Straat and Number or Rural Routa Numbar, City or Town, State, Zip Coda): P.O. Box 45 - Rusty Acres Lane Wye Mills, MD. 21679

20a. Mathod of Disposition: 1☐Burial 2☑Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)
20b. Place of Disposition (Nema of cematery, cremetory or othar place): Mid Shore Cremation
Data: 12/5/03
20c. Location - City or Town, Stata: Cambridge, MD

21. Signatura of Funaral Sarvice Licensaa: ▶ Janelle C. Henry
22. Nama and Addrass of Facility: Henry Funeral Home, P.A. 510 Washington St. Cambridge, MD. 21613

**Physician /Medical Examiner**

23a. Part I. Entar tha disaasa, or complications that caused tha death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on each lina.

Approximata Interval Batwaen Onsat and Daath

Immediata Causa (Final disaasa or condition rasulting in death): a. Cerebrovascular Accident — 1 month

Dua to (or as a consaquance of):

Sequantially list conditions, if any, leading to immadiata causa. Enter Undarlying Causa (Disaasa or injury that initiated evants resulting in death) Last:
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditiona** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. **Did tobacco uae contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Wara autopsy findings availabla prior to complation of causa of death? 1☐Yas 2☐No

25. Was casa refarrad to medical examiner? 1☐Yas 2☒No

26. Placa of Daath (Chack only one): Hospital: 1☐Inpatiant 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Rasidance 6☐Othar (Specify)

27. Manner of Daath: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending invastigation 6☐Could not be datarmined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Numbar or Rural Route Numbar, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and place, and due to the ceuse(s) and manner es stated. 2☐**Medical Examinar:** On tha basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to tha cause(s) and mannar statad.

29b. Signatura and title of cartifiar: ▶ MD
29c. Licensa number: D35284
29d. Date signed (Month, Day, Year): 12/4/03

30. Name and addrass of parson who complatad cause of daath (Item 23a) (Type, Print): ANDREA ALLEN MD 219 S. Washington ST. Easton MD 21601

**State Registrar**

31. Data filed (Month, Day, Year): DEC 05 2003
32. Registrar's Signatura:

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41181

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| CHARLES RICHARD TRUITT | Dec. 6, 2003 | 5:00P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 7900 Green Lewis Road | Willards | Wicomico |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220 28 1905 | 1☒M 2☐F | 72 Yrs. | | | Oct. 14, 1931 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Willards | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7900 Green Lewis Road | 21874 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Timber Cutter | Lumber Industry |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Clarence Truitt | Elsie Smith |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Louise D. Truitt | 7900 Green Lewis Road Willards, MD 21874 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | New Hope Cemetery | Dec. 10,2003 | Willards, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| W. Hill Burbage | The Burbage Funeral Home 108 William St. Berlin, MD 21811 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MASSIVE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. RENAL FAILURE

Due to (or as a consequence of):

d. HYPERTENSION

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) WOODS WHILE HUNTING |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| M Grady M.D. | D 58798 | 12-8-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ULAH C. GONZALEZ, M.D., 314 FRANKLIN AVE. BERLIN, MD 21811

C.H.4

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41182

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| JERRY EDWIN TILLER | 12 | 2 | 2003 | 1348 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Atlantic General Hospital | Berlin | Worcester |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-44-7320 | X 1 M 2 F | 55 Yrs. | | | 3/8/1948 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Worcester | Ocean Pines | X 1 Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4 Driftwood Lane | 21811 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| X 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Teacher | School System |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Kenneth Eugene Tiller | Pauline Powers |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Larry Tiller | 511 Paradise RD Aberdeen, MD 21001 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Cape Henlopen Crematory | 12/3/03 | Frankford, DE |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| W. Reid Burbage | The Burbage Funeral Home 108 William St. Berlin, MD 21811 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pancreatic CA (metastatic) | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 X No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 Yes 2 X No | Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Physician | D58612 | 12-2-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrea K Baier MD 9733 Healthway Dr Berlin, MD 21811

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 04 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Jerry Tiller DoB 3/8/1948 219-44-7320 DoD 12/2/2003 1348

C.H.3

Roland K. Talley
03-7904
AKG

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar UNPEND ITEM 23a,PII&27 PER ME G827 1708/04 JH

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 [illegible]183

2832

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Roland | Kenneth | Talley | December 9, 2003 | 08:06 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 45112 Lighthouse Road | Piney Point | St. Mary's |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-26-0574 | 1 M 2 F | 73 Yrs. | | | Feb. 7, 1930 | Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | St. Mary's | Piney Point | 1 Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 45112 Lighthouse Road | 20674 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 No If Yes, Give Year or Dates: 1950-1954 | 1 Yes 2 No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Electronic Technician | U.S. Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Ernest C. Talley | Mabel Warwick |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Raymond J. Talley / Nephew | 45112 Lighthouse Road, Piney Point, Maryland 20674 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Brinsfield-Echols | 12-14-2003 | Charlotte Hall, MD |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| Edward N. Brinsfield, Jr. | M00052 | Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE BRONCHOPNEUMONIA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

CHRONIC ALCOHOLISM

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 No | 1 X Yes 2 No |

25. Was case referred to medical examiner? 1 XX Yes 2 No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 XX Other (Specify) At scene

27. Manner of Death: XX 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Ling Li M.D | O.C.M.E. | December 10, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ling Li, M.D 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 16 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41184

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Louise | B. | Wildes | December 14, 2003 | 1020am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Buckingham's Choice | Adamstown | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 374-58-4670 | 1☐M 2☒F | 96 Yrs. | | | November 3, 1907 | Michigan |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Adamstown | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3200 Baker Circle | 21710 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Edward Kottke | Emma Fox |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| David J. Peterson/Son | 6398 Fairway Drive West, Fayetteville, PA, 17222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Smithsburg Crematory | 12/16/2003 | Smithsburg, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ P. Susan McMillan MO1202 | Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE MYOCARDIAL INFARCTION | 2 DAYS |
| Due to (or as a consequence of): | b. ASCVD | 10 YEARS |
| Due to (or as a consequence of): | c. | |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☑No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ JULIO MENOCAL MD | D-31912 | 12/15/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julio Menocal, MD, 1564 Opposumtown Pike, Frederick, Maryland, 21702-4359

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ Jeanne G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41185

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Roby Lee | Whitfield, Sr. | | Dec 5, 2003 | 3:45 A M |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | |
| Genises Health Care | Annapolis | | Anne Arundel | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579 03 8914 | 1 XX M 2 F | 87 Yrs. | | | June 7, 1916 | North Carolina |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Shady Side | 1 Yes 2 XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4978 Lerch Drive | 20764 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Bleck, White, etc. |
|---|---|---|---|
| 1 Never Married 2 XX Married 3 Widowed 4 Divorced | 1 Yes 2 XX No If Yes, Give Year or Dates: | 1 Yes 2 XX No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | Sales | Real Estate |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| UNKNOWN | Lacey Euphalai Whitfield |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Ellen Whitfield (Wife) | 4978 Lerch Drive, Shady Side, MD 20764 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Cedar Hill Cemetery | Dec 9, 2003 | Suitland, Maryland |

21. Signature of Funeral Service Licensee: ▶ R. L. Tripp M0340

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Prostate cancer | 6y |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 X Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ [signature] | D32036 | 12/5/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary T. Sprouse 2108 Dividock Drive Chester, MD 21619

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 11 2003 | [signature] |

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ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41186

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Frances E. Williams

2. Date of Death Month Day Year: November 30, 2003

3. Time of Death: 12:20 am

4a. Facility Name *(If not institution, give street and number)*: Long View Nursing Home

4b. City, Town, or Location of Death: Manchester

4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 215-03-1515

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jul 12, 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Hampstead

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3899 Beckleysville Road

10f. Zip Code: 21074

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Control Clerk

16b. Kind of Business/Industry: College

17. Father's Name *(First, Middle, Last)*: Robert Jump Bowen

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Whrs

19a. Informant's Name/Relationship *(Type, Print)*: William H. Williams, husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3899 Beckleysville Road, Hampstead, MD 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crest Lawn Memorial Gard — Date: 12/03 2003

20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: M00723 ▶ Steven W Eline

22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Alzheimers Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Raymond Miller

29c. License number: D47683

29d. Date signed *(Month, Day, Year)*: 12/2/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Raymond Miller 25 Main Street Suite 200 Reisterstown MD 21136

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 4

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 03 2003

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41187

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Vanessa Renee Walker

2. Date of Death Month: Dec Day: 04 Year: 2003

3. Time of Death: 1352 M

4a. Facility Name (If not institution, give street and number): Carroll Hospital Center

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 051-56-7957

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 44 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 20 1959

9. Birthplace (State or Foreign Country): CA

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Taneytown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 121 Pumpkin Drive

10f. Zip Code: 21787

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Customer Service

16b. Kind of Business/Industry: Lowes

17. Father's Name (First, Middle, Last): Cleveland Taylor

18. Mother's Name (First, Middle, Maiden Surname): Delores Tookes

19a. Informant's Name/Relationship (Type, Print): Myra Gassaway/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 121 Pumpkin Drive Taneytown, MD 21787

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation, Inc

Date: 12/8/2003

20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: John K A[illegible]

22. Name and Address of Facility: Fritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic Encephalopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypotension

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☒ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

26. Place of Death (Check only one) Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 039582 MD

29d. Date signed (Month, Day, Year): 12/4/03.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5980 S. Hosain MD 447 E Main street Westminster MD 21157

**State Registrar**

31. Date filed (Month, Day, Year): DEC 08 2003

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-I show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 CW

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41188

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Robert L. Weckesser, Sr. | Dec. 5, 2003 | 6:30 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1507 Buckhorn Road | Sykesville | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-32-5444 | 1 [X] M 2 [ ] F | 68 Yrs. | | | Aug. 6, 1935 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Carroll | Sykesville | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1507 Buckhorn Road | 21784 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | Tile and Marble Setter | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harry Weckesser | Matilda Heck |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Robert L. Weckesser, Jr./Son | 1507 Buckhorn Road, Sykesville, MD 21784 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Crest Lawn Memorial Gar. | 12/8/2003 | Marriottsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Jeffry W. Zumbrun | J.N. Zumbrun F.H. & Mon. Co. 6028 Sykesville Road, Eldersburg, MD 21784 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Pancreatic CA — Approximate Interval: 3mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D37949 | Dec. 5th 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander Boyd Jr. MD, 240 Scenery Dr. Suite #305, Westminster MD, 21157

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 08 2003 | |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41189

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Tanya Lea Williar

2. Date of Death (Month, Day, Year): DECEMBER 5, 2003

3. Time of Death: 1:18 A M

4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-86-9927

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 41 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 6, 1962

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Hampstead

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1804 Harrowsmith Court

10f. Zip Code: 21074

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse Practitioner

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Martin Watts

18. Mother's Name (First, Middle, Maiden Surname): Betty Jo Smith

19a. Informant's Name/Relationship (Type, Print): David W. Williar Sr, husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1804 Harrowsmith Ct, Hampstead, MD 21074

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremations

Date: 12/06/2003

20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: ▶ Steven W Eline MD 723

22. Name and Address of Facility: Eline Funeral Home 934 South Main St, Hampstead, MD 21074

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CARCINOMA — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☒ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A. J. Helou, M.D.

29c. License number: D17695

29d. Date signed (Month, Day, Year): December 5, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABDALLAH J. HELOU M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

WJL 6

**State Registrar**

31. Date filed (Month, Day, Year): DEC 09 2003

32. Registrar's Signature: ▶

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41190

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Maud-Ellen Andrews | Dec 16 2003 | 7:00p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2941 Manns Ave. | Parkville | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | If Under 1 Year: Days | If Under 24 Hrs.: Hours | If Under 24 Hrs.: Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 212-18-8030 | 1☐M 2☒F | 87 Yrs. | | | | | Dec 4 1916 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Parkville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2941 Manns Ave. | 21234 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4+ | Math Teacher | Baltimore Junior College |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Leo A. Zimmerman | Emily Maude Shipley |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Leo A. Zimmerman II | 2941 Manns Ave. Baltimore, MD 21234 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Evans Funeral Chapel - | Dec 31, 2003 | Forest Hill MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Kristal Wells | 2325 York Rd Timonium MD Peaceful Alternatives Funeral & Crem Center |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Flu Syndrome | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Fever

Diarrhea

Anorexia

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D29085 | Dec 21 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Allan Chiecus 5310 Old Court Rd Randallstown, MD Suite 201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend Item #10g&14 per In G826 12/22/03 tas

# Certificate of Death

Reg. No. 2003 41191

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| MICHAEL | ANYOKA | | December 15 2003 | 9:12 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GOOD SAMARITAN Hospital | Baltimore | Baltimore city |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| UNKN | 1 [X] M 2 [ ] F | 72 Yrs. | | | 4-10-31 | Africa |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | NA | Baltimore | [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4607 Lasalle Ave. | 21206 | ~~USA~~ Africa |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | African Specify: ~~Black~~ |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 4th grade | | Never Worked | NA |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|---|
| Bwocha | Anyoka | Unkn |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Peterson Nyamboga Son | 4607 Lasalle Ave., Baltimore, Md. 21206 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Family Plot | 1-2-03 | Nyamira Kenya, Africa |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gladys Warren | March F.H. East Baltimore, Md. 21202 1101 E. North Ave. |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Rhabdomyolysis | |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Aseptic meningitis | 2 |
| Due to (or as a consequence of): | | |
| | c. Sepsis | 2 |
| Due to (or as a consequence of): | | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [X] Yes 2 [ ] No | 1 [ ] Yes 2 [X] No |

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one) — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) — 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ johny Salameh M.D. | RES 000 | December, 15, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHNNY SALAMEH 5601 Loch Raven Blvd. Baltimore, MD 21239

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ [signature] |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MICHAEL ANYOKA

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41192

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| EVA AZZARO | | DECEMBER 20, 2003 | 6:10 P.M. |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | |
| MULTI MEDICAL CENTER | TOWSON | BALTIMORE | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-28-9462 | 1☐ M 2☒ F | 95 Yrs. | | | 10/28/1908 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | TOWSON | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8440 LOCH RAVEN BLVD. | 21286 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7TH GRADE | | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOHN WINKLER | ESTELLE FAITZ |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ROBERT AZZARO SON | 8440 LOCH RAVEN BLVD. TOWSON, MD 21286 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | PARKWOOD CEMETERY | 12/23/2003 | BALTIMORE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Heather N. Hayes | THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CONGESTIVE HEART FAILURE | 2 WEEKS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. AORTIC STENOSIS | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☑ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D43945 | DEC 22 7:03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HANS ALETEN MD 7515 OSLER DRIVE TOWSON MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41193

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Bruce Allen
2. Date of Death (Month, Day, Year): DECEMBER 14 2003
3. Time of Death: 1020 AM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 456-46-1348
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 17 1935
9. Birthplace (State or Foreign Country): TX

Usual Residence of Decedent

10a. State: PA
10b. County:
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1611 Woodlands Run
10f. Zip Code: 21742
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Software design Engineer
16b. Kind of Business/Industry: Computer

17. Father's Name (First, Middle, Last): Dewitt Allen
18. Mother's Name (First, Middle, Maiden Surname): Mary Gladys McGowan

19a. Informant's Name/Relationship (Type, Print): Diane Silas
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1611 Woodlands Run Hagerstown, MD 21742

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 12-23-03
20c. Location - City or Town, State: Balto, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: IIAM 1232 Midvale Dr. Jessup, PA 18434

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Cerebral Bleed — 17.5 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Acute Coronary Syndrome — 2 days
c. Due to (or as a consequence of): Cerebral Vascular Disease — 15 years
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
None

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: , MD
29c. License number: 26205
29d. Date signed (Month, Day, Year): 12/14/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Imad A. Alhaddad, MD Johns Hopkins Hospital, Baltimore, MD

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature: 21287

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WILLIAM ANDERSON
03-07791
RKD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41194

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William Anderson
2. Date of Death (Month, Day, Year): DECEMBER 4, 2003
3. Time of Death: 8:27P. M
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: unk
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 52 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Now 1, 1951
9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6834 Loch Raven Blvd
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: unk — 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No unk — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): O.C.M.E.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 Penn Street Bsltimore, MD 21201

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): Found 12-4-03
28b. Time of Injury: Found 7:48PM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Deceased pedestrian struck by vehicle
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Road
28f. Location (Street and Number or Rural Route Number, City or Town, State): 6834 Loch Raven Blvd Baltimore, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 5, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41195

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret D. Bernstein
2. Date of Death (Month, Day, Year): December 22 2003
3. Time of Death: 2:18 AM
4a. Facility Name (If not institution, give street and number): Good Samaritan Hosp.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 125-03-4392
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 24 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6920 Wonachie Rd.
10f. Zip Code: 21239
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Albert Arnold Dugan
18. Mother's Name (First, Middle, Maiden Surname): Wilhelmina E. Schlitzberger

19a. Informant's Name/Relationship (Type, Print): Maurice I. Bernstein, Jr. Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14210 Dove Creek Way #303 Sparks, MD 21152

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem
Date: Dec 24 2003
20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Leslie A. Wells
22. Name and Address of Facility: 2325 York Rd Timonium MD Peaceful Alternatives Funeral & Crem. Care

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. RESPIRATORY FAILURE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rakesh Malik M.D.
29c. License number: RES000
29d. Date signed (Month, Day, Year): December 22 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAKESH MALIK, GOOD SAMARITAN HOSPITAL, BALTIMORE, MD.

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BERNSTEIN, MARGARET D

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41196

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Pearl Boston
2. Date of Death (Month, Day, Year): December 12 2003
3. Time of Death: 4:15 PM
4a. Facility Name (If not institution, give street and number): Mercy Medical Center
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 218-44-9653
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02 07 45
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6646 Collinsdale Road
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+): 2yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled
16b. Kind of Business/Industry: Disabled

17. Father's Name (First, Middle, Last): Marion Holly Sr.
18. Mother's Name (First, Middle, Maiden Surname): Gertrude Walborrow

19a. Informant's Name/Relationship (Type, Print): Kim Holly-Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6726 Campfield Road, Baltimore Md 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park
Date: 12/19/03
20c. Location - City or Town, Stete: Randallstown, Md

21. Signature of Funeral Service Licensee: Dala March
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — Approximate Interval Between Onset and Death: 1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Secondary decubitus ulcer — Unknown
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: 05036
29d. Date signed (Month, Day, Year): December 12, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JULIA BOWMAN 3015 7 PAUL PL BALTIMORE MD 21218

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41197

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Genevieve Morgan Bragg | December 16, 2003 | 9:15 PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 8007 Charlesmont Road | Baltimore | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 231-46-3896 | 1☐M 2☒F | 92 Yrs. | | | Feb 10, 1911 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Baltimore | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8007 Charlesmont Road | 21222 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Clarence D. Morgan | Maude Magness |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Carrington Morgan Bragg (Son) | 8007 Charlesmont Road Baltimore, MD 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mt. Zion United Methodist Church Cem | 12-19-03 | Esmont, Virginia |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Dennis Settimore | Thacker Funeral Home 650 Valley St., Scottsville, VA 24590 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 1 Week |
| Due to (or as a consequence of): | b. Dementia | 10 years |
| Due to (or as a consequence of): | c. | |
| Due to (or as a consequence of): | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Reed D Riley MD | D47560 | December 17, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Reed D. Riley M.D. 4924 Campbell Blvd. Baltimore MD 21236

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41198

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CAROLYN BAILEY
2. Date of Death (Month, Day, Year): DECEMBER 17 2003
3. Time of Death: 9254 M
4a. Facility Name (If not institution, give street and number): U. OF MARYLAND SHOCK TRAUMA
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: 217-46-0546
6. Sex: 1☐ M 2☒ F (X)
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 11, 1945
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No (XX)
10e. Street and Number: 9344 Canterbury Riding
10f. Zip Code: 20723
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2(XX) Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2(XX) No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2(XX) No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4 +
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chemistry Professor
16b. Kind of Business/Industry: College

17. Father's Name (First, Middle, Last): Harry W. Bailey
18. Mother's Name (First, Middle, Maiden Surname): Vivian Hopkins

19a. Informant's Name/Relationship (Type, Print): LeRoy V. Ruby / spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9344 Canterbury Riding Laurel, Maryland 20723

20a. Method of Disposition: 1(X) Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Gardens
Date: 12/20/03
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: [signature] /M00770
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SUBDURAL HEMATOMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

[signature] M.D. INFORMATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2(X) No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Bronchitis

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2(X) No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2(X) No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2(X) No

25. Was case referred to medical examiner? 1(X) Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1(X) Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2(X) Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 12/16/2003
28b. Time of Injury: 4:30a M
28c. Injury at Work? 1☐ Yes 2(X) No
28d. Describe how injury occurred: Fall
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 9344 Canterbury Riding, Laurel, MD 20723

29a. Certifier (Check only one): 1(X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: AU417
29d. Date signed (Month, Day, Year): DECEMBER 17 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIE-CARMELLE ELIE 22 SOUTH GREENE ST. BALTIMORE, MD 21202.

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41199

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Dorothy Ann Bedard | DEC 17 2003 | 3:55 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| CIVISTA MEDICAL CENTER | LAPLATA | CHARLES |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-44-9210 | 1☐M 2☒F | 69 Yrs. | | | JUNE 16, 1934 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Rockville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1105 Allison Drive | 20851 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Domestic |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| Joseph Elmer Stonestreet | Mabel Frances Jenkins |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Deborah Ann Henry/Daughter | 20011 Mulberry Fields Road Leonardtown, MD 20650 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Crematory Inc. | 12-19-03 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Edward A. Gregorchik | Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATHERO-SCLEROTIC HEART DISEASE
CHRONIC RENAL FAILURE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check on one) Hospital: | Other: |
|---|---|---|
| 1☐Yes 2☒No | 1☒Inpatient 2☐ER/Outpatient 3☐DOA | 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ V. Anmangandla | D-26064 | 12-17-2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIDYASAGAR ANMANGANDLA MD
RT 5 & GOLDEN BEACH RD PO BOX 282 CHARLOTTE HALL MD 20622

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Dorothy Bedard

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41200

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: William Wayne Bowe
2. Date of Death (Month, Day, Year): December 19, 2003
3. Time of Death: 6:25 AM
4e. Facility Name *(If not institution, give street and number)*: Baltimore V.A. Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-56-2957
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 54 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yeer)*: AUG 4, 1949
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 5040 Erdman Avenue
10f. Zip Code: 21205
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: Vietnam
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic
16b. Kind of Business/Industry: Automotive

17. Father's Neme *(First, Middle, Last)*: Reuben Bowe
18. Mother's Name *(First, Middle, Maiden Surname)*: June Newell

19a. Informant's Name/Relationship *(Type, Print)*: Rose A. Klingmeyer/sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3533 Northway Drive Parkville, MD 21234

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Metro Crematory, Inc. — Date: 12/20/03
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald — Dawn F. McDonald
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Renal Failure
Due to (or as a consequence of):
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last: b. End Stage Liver Disease
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner ot Deeth: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Holly B Hindman, MD
29c. License number: P17669
29d. Date signed *(Month, Day, Year)*: December 19, 2003

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): Holly B. Hindman 10 N. Green St, Baltimore, MD 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 22 2003
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attanding Physician:** The law requires that tha death certificate be executed within 24 hours after deeth.
**To the Funeral Director:** After this certificata has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41201

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Samuel Bernstein

2. Date of Death (Month, Day, Year): December 19, 2003

3. Time of Death: 2:00p M

4a. Facility Name (If not institution, give street and number): Genesis Eldercare Perring Parkway

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 150-09-0306

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APR 1, 1912

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Perry Hall

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9511-G Kingscroft Terrace

10f. Zip Code: 21128

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Business Owner

16b. Kind of Business/Industry: Souvenir Shop

17. Father's Name (First, Middle, Last): Morris Bernstein

18. Mother's Name (First, Middle, Maiden Surname): Mary Wiatrak

19a. Informant's Name/Relationship (Type, Print): Marsha A. Dyer/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9511-G Kingscroft Terrace Perry Hall, MD 21128

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.

Date: 12/20/03

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: George E. MacNabb

22. Name and Address of Facility: Cremation Society of Maryland, Inc, 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Progressive Decline

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Degenerative Joint Disease

Due to (or as a consequence of):

d. Anaemia

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 31464

29d. Date signed (Month, Day, Year): 12/19/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHOAIB A. HASHMI 821 N. EUTAW ST Suite 308, Balt MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Michael Bowden
03-7805
AKG

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM #23a&27 PER ME G826 12/29/03 JH

# Certificate of Death

Reg. No. 2003 41202

2834

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Michael | Edward | Bowden | December 5, 2003 | 4:30 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Howard County General Hospital | Columbia | Howard |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 422-94-8111 | 1 X M 2 ☐ F | 43 Yrs. | | | | | April 14, 1960 | Alabama |

**Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| AL | Madison | Owens Cross Roads | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 119 Markyle Drive | 35763 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Program Manager | Aerospace |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Otis Bowden | Marlene Brown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lou Ann Bowden (Spouse) | 119 Markyle Drive Owens Cross Roads, AL 35763 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Twickenham Mem. Gdns. | 12-10-03 | Hampton Cove, AL |

21. Signature of Funeral Service Licensee: Allen Woodall

22. Name and Address of Facility: Twickenham Funeral Home 11611 S. Mem. Pkwy. Huntsville, AL

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 ☐ Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown | 1 ✓ Yes 2 ☐ No | 1 ☐ Yes 2 ☐ No |

25. Was case referred to medical examiner? X Yes 2 ☐ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Marjorie Ann Gill | O.C.M.E. | December 6, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARJORIE A. KOREN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | Frances G. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41203

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JAMES W. BOLTON
2. Date of Death: Month DECEMBER Day 17, Year 2003
3. Time of Death: 3:15 PM

4a. Facility Name (If not institution, give street and number): BALTIMORE REHABILITATION EXTENDED CARE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Not Applicable

**Funeral Director**

5. Social Security Number: 218-26-5388
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 28, 1932
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Not Applicable
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2708 Wilkens Avenue
10f. Zip Code: 21223
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 5/22/1948 1/7/1949
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Guard
16b. Kind of Business/Industry: Security

17. Father's Name (First, Middle, Last): Benjamin H. Bolton
18. Mother's Name (First, Middle, Maiden Surname): Nellie F. Shifflett

19a. Informant's Name/Relationship (Type, Print): Mae V. Bolton-Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2708 Wilkens Avenue, Baltimore, Maryland 21223

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Crematory @ Loudon Park
Date: 12-22-2003
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Lisa S. Jefferson
22. Name and Address of Facility: Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER WITH BRAIN METASTASIS — ONE MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ISCHEMIC CARDIOMYOPATHY
CHRONIC OBSTRUCTIVE LUNG DISEASE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Aurora C. Tan, M.D.
29c. License number: D14958
29d. Date signed (Month, Day, Year): DECEMBER 17, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AURORA C. TAN 3900 LOCH RAVEN BOULEVARD, BALTIMORE, MD 21218

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature: James B. Jones

5+1

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41204

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| John Earl Burgess | December 6, 2003 | 12:00 PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 900 Shipmaster Court | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578-24-5186 | 1 X M 2 ☐ F | 79 Yrs. | | | Sept 21, 1924 | Washington DC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Annapolis | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 900 Shipmaster Court | 21401 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates: '42-45 | 1 ☐ Yes 2 X No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 5+ | research analyst | library of congress |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Earl Burgess | Elizabeth Burgess |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dorothy Burgess/spouse | 900 Shipmaster Court Annapolis, MD 21401 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Annapolis, MD 21401 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown | 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Amee Yu, MD | D55187 | 12/16/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR, AMEE YU

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41205

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert O. Booth
2. Date of Death (Month, Day, Year): December 16, 2003
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, give street and number): Beverly Healthcare
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 217-28-5618
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): Oct 31, 1930
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 30 N. Place
10f. Zip Code: 21701
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): Sherman Osborne Booth
18. Mother's Name (First, Middle, Maiden Surname): Hazel Elizabeth Corder

19a. Informant's Name/Relationship (Type, Print): Yvonne Perry/friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 315 Redwood Avenue Frederick MD 21701

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**To Be Completed by Funeral Director**

TIME OF DEATH: 500AM

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Renal Insufficiency — YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Diabetes Millutis — YRS
Due to (or as a consequence of):
c. Hypertension/ATRIAL Fibrillation — YRS
Due to (or as a consequence of):
d. CORONARY HEART Disease — YRS

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Depression, gastroparesis, hypoalbuminemia, anemia, Hypothyroidism, Hyperlipidemia, peptic ulcer disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Allen Reilly MD
29c. License number: D54749
29d. Date signed (Month, Day, Year): 12 16 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALLEN REILLY, MD, 30 North Ave, Frederick, MD 21701

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P1: Robert O. Booth Date of Death 12/16/2003

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41206

Patient knows Wilton Bober

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|
| WILTON | BOBER | Dec | 18 | 2003 | 3:08 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-09-9451 | 1 X M 2 F | 85 Yrs. | | | APR. 21, 1918 | MD. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1840 REISTERSTOWN ROAD | 21208 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 X Yes 2 No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | OWNER | B. BOBER & COMPANY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| BENJAMIN BOBER | ANNA BENESH |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. SHELLEY GORDON/DAUGHTER | 2713 MOORES VALLEY DRIVE BALTIMORE, MD. 21209 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | BETH TFILOH CONG. | 12/ 19/2003 | WOODLAWN, MD. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility SOL LEVINSON & BROS.INC. 8900 REISTERSTOWN ROAD PIKESVILLE,MD.21208

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Coronary Artery Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) _____ 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 X **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ Karen J. Rybak, MD | RES-000 | Dec 18, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Karen J Rybak MD Sinai Hospital of Baltimore

**State Registrar**

31. Date filed (Month, Day, Year) DEC 22 2003

32. Registrar's Signature ▶ [signature]

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41207

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Anna S. Cermak
2. Date of Death (Month, Day, Year): December 18, 2003
3. Time of Death: 2:18pm M
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 217-18-9378
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 3 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: TOWSON
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 409 Virginia Ave. #323
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired): office worker
16b. Kind of Business/Industry: office

17. Father's Name (First, Middle, Last): unk. Cermak
18. Mother's Name (First, Middle, Maiden Surname): Barbara Dopihal

19a. Informant's Name/Relationship (Type, Print): Richard Beyson - Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1907 Captain Dettle Rd. Reisterstown, MD 21136

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bohemian Nat. Cemet. Date: Dec 22 2003
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Kristal Wells
22. Name and Address of Facility: 2325 York Rd Timonium MD Peaceful Alternatives Funeral & Crem. Cntr.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
- Hypercalcemia
- Breast cancer
- multiple bone metastasis

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George Beson MD
29c. License number: D12732
29d. Date signed (Month, Day, Year): 12/19/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE A. BESON MD 6701 Charles St - Baltimore Md 21204

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To Be Completed by Funeral Director**

Cermak Anna.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41208

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Rosa Elidia Cruz-Miranda | 12/20/2003 | 1:30 am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Gilchrist Hospice | Baltimore MD | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 583-93-4975 | 1☐ M 2☒ F | 82 Yrs. | | | Sept 23, 1921 | PR |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Randallstown | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9004 Hamor Road | 21133 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☒ Yes 2☐ No Specify: Puerto Rican | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Buenaventura Cruz | Rosa Miranda |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jesus M. Miranda | 9004 Hamor Road Randallstown Maryland 21133 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify) | Old Municipal Cemetery | 12/24/2003 | Rio Piedras, PR |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Victor P. Doda, Jr. | Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. metastatic Colon Cancer | Months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) — 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| W. Anthony Riley, MD | 035205 | December 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**To be completed by the Physician or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completed or filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**
**Division of Vital Records, P.O. Box 68760,**

(1:30 am) SATURDAY, December 20th 2003 @ 0130

ROSA Elidia Cruz MIRANDA

Kevin Lee Chapman
03-08138
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: UNPEND ITEM 23a,27 &28a-f PER ME G827 1/09/04 Jh

# Certificate of Death

Reg. No. 2003 41209

2835

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Kevin Lee Chapman
2. Date of Death (Month, Day, Year): December 17, 2003
3. Time of Death: 11:06 AM
4a. Facility Name (If not institution, give street and number): 9502 Perry Hall Boulevard, Apt. 103
4b. City, Town, or Location of Death: Perry Hall
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-98-5300
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 21 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 31 1982
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 9502 Perry Hall Blvd.
10f. Zip Code: 21236
10g. Citizen of What Country: USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12YRS- | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UNEMPLOYED
16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): William Pereira
18. Mother's Name (First, Middle, Maiden Surname): Karen Jo Chapman

19a. Informant's Name/Relationship (Type, Print): Karen Jo Chapman
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9502 Perry Hall Blvd #103 Baltimore, MD 21236

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evans Funeral Chapel & Cr. Date: Dec 31, 2003
20c. Location - City or Town, State: Forest Hill, MD

21. Signature of Funeral Service Licensee: Keesha Wells
22. Name and Address of Facility: 2325 York Rd Timonium, MD Peaceful Alternatives Funeral & Cremation Ctr

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. TRAMADOL INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 X Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) at scene

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 X Could not be determined
28a. Date of Injury (Month, Day Year): found 12-17-03
28b. Time of Injury: found 10:58a M
28c. Injury at Work? 1 ☐ Yes 2 X No
28d. Describe how injury occurred: unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): RESIDENCE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 9502 PERRY HALL BLVD., APT 103 NOTTINGHAM, MD

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 19, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Maryann Colby
03-8024
AKG

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM 23a,27&28a-f PER ME G827 1/07/04 JH

# Certificate of Death

Reg. No. 2003 41210

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Mary Ann Colby | December 13, 2003 | 10:34 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 711 Hillcrest Drive | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 471-64-3541 | 1☐M 2☒F | 53 Yrs. | | | Feb. 9, 1950 | Minnesota |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Annapolis | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 711 Hillcrest Drive | 21401 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Officer Manager | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Elias Gonzales | Bonnie Spurr |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Christopher Colby (Husband) | 711 Hillcrest Drive, Annapolis, MD 21401 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Crematory | 12/17/2003 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MIXED DRUG INTOXICATION

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☒Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) At scene

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | found 12-13-03 | found at 10:15a M | 1☐Yes 2☒No | subject ingested drugs |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| RESIDENCE | 711 HILLCREST DR. ANNAPOLIS,MD. |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] M.D | O.C.M.E. | December 14, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LING LI. M.D
111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2836

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41211

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| PHYLLIS A CANNETI | 12 | 16 | 2003 | 08:23 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHNS HOPKINS BAYVIEW | BALTIMORE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 229-28-2803 | 1☐M 2☒F | 75 Yrs. | | | | | April 14,1928 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Dundalk | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 651 South 48th Street | 21224 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 Years | | Housewife | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Robert Ragland | Thelma Bareford |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Louis F. Canneti (Husband) | 651 South 48th Street Baltimore, Maryland 21224 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment | Gardens of Faith Cem. | 12/19/2003 | Rosedale, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Paul L Hunstock Jr | Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIO RESPIRATORY FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. SEPSIS — DAYS
Due to (or as a consequence of):
c. CAVITATING PNEUMONIA — DAYS
Due to (or as a consequence of):
d. LUNG CANCER — YEARS

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD, Anemia
Hypertension

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Kapil Parakh MD | 33709 | 12/16/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHNS HOPKINS BAYVIEW, BALTIMORE Kapil Parakh MD 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ Brenda G Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41212

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| R. Kendall Coffman | December 18, 2003 | 2:30 p.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Gilchrist | Towson | Baltimore Co. |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-10-3042 | 1 X M 2 ☐ F | 89 Yrs. | | | Sept. 16, 1914 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | n/a | Baltimore | X 1 Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3518 Woodring Avenue | 21234 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WWII | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | 1 yr. | Laborer | Steel Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Samuel Coffman | Martha Amelia Kendall |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Agnes C. Coffman / wife | 3518 Woodring Avenue Baltimore, Maryland 21234 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Moreland Mem. Park | Dec. 22, 2003 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael E. Canapp | Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Dementia - Mixed | 4 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check on one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) Hospice

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D 58303 | December 18 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tom J. Charles MD 6601 N. Charles St Baltimore MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | Denise B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Kendall Coffman December 18, 2003 2:30pm

10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #5 PER FH G826 12/22/03 JH

# Certificate of Death

Reg. No. 2003 41213

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): RAHUE, COX SR.
2. Date of Death: Month DEC Day 13 Year 2003
3. Time of Death: 1220P M

4a. Facility Name (If not institution, give street and number): MARYLAND GENERAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: MD

**Funeral Director**

5. Social Security Number: ~~218-64-2095~~ ~~999-99-9999~~
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 8 1957
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1612 N. Bentalou St
10f. Zip Code: 21216
10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Service

17. Father's Name (First, Middle, Last): Jehu Cox
18. Mother's Name (First, Middle, Maiden Surname): Iola Hutchins

19a. Informant's Name/Relationship (Type, Print): Rahue Cox, Jr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1612 Bentalou St. Balto MD 21229

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Date: 12-23-03
20c. Location - City or Town, State: Balto, MD

21. Signature of Funeral Service Licensee: Bernard Rand
22. Name and Address of Facility: IIAM 1232 Midvalley Dr. Jessup, PA 18434

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Intracerebral Bleed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Bhavneet Singh MD
29c. License number: 89503
29d. Date signed (Month, Day, Year): 12/13/2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bhavneet Singh M.D. C/o Maryland General Hospital

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41214

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

| | | | |
|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): Winslow Clark | | 2. Date of Death (Month, Day, Year): 12 16 2003 | 3. Time of Death: 8 30 pm |
| 4a. Facility Name (If not institution, give street and number): Baltimore Rehabilitation Extended Care | 4b. City, Town, or Location of Death: Baltimore | 4c. County of Death: | |
| 5. Social Security Number: 219-07-1993 | 6. Sex: 1 X M 2 F | 7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min. |
| 8. Date of Birth (Month, Day, Year): 9/30/1919 | 9. Birthplace (State or Foreign Country): Maryland | | |

**Usual Residence of Decedent**

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5640 Woodmount Avenue | 21239 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 Widowed 4 X Divorced | 1 X Yes 2 No If Yes, Give Year or Dates: '42-45 | 1 Yes 2 X No Specify: | Specify: black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2 | picture framer | art |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Shelly Clark | Agnes Morton |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Andre Hunt/son | 9106 Amber Oaks Way Owings Mills, MD 21117 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. prostate cancer | 2 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): metastasis of prostate cancer | 15 months |
| | c. Due to (or as a consequence of): Pancytopenia | years |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus
Hypertension

| 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown | | |
|---|---|---|
| | 24a. Was an autopsy performed? 1 Yes 2 X No | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |

| 25. Was case referred to medical examiner? 1 Yes 2 X No | 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) |
|---|---|

| 27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury M | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| Augustin Chyu, M.D | D-18298 | 12/16/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Augustin Chyu, M.D 3900 Loch Raven Blvd. Baltimore, MD 21218

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## *Certificate of Death*

Reg. No. 2003 41215

DUKES, ANTHONY 12/15/03 AT 5:45AM

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Dete of Death Month / Dey / Yeer | 3. Time of Death |
|---|---|---|---|---|
| Anthony | M. | Dukes | DECEMBER 15, 2003 | 5:45AM |

| 4a Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Deeth |
|---|---|---|
| Stella Maris Mercy | Baltimore | NA |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. lest birthdey) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-58-3885 | 1☒ M 2☐ F | 49 Yrs. | | | 7-31-54 | Md. |

Usual Residence of Decedent

| 10a. Stete | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | NA | Baltimore | ☒ Yes 2☐ No |

| 10e. Street end Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2213 Homewood Ave. | 21218 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U,S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☐ No If Yes, Give Year or Dates: X | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Eduction (Specify only highest grede completed) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10th grade | | | Oles Envelope |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Neme (First, Middle, Maiden Surname) |
|---|---|
| Horace Dukes | Helen Barnett |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| Maggie Jennings Sister | 2213 Homewood Ave., Baltimore, Md. 21218 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | King Mem. Pk. | 12-20-03 | Randallstown, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gladys Warner | March F.H. East 1101 E. North Ave. Baltimore, Md. 21202 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. lung cancer

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part t.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Yeer) |
|---|---|---|
| ▶ | D40854 1 | 12/16/2003 |

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

David Risberg 301 St. PAUL PL Baltimore MD. 21202

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ |

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41216

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Denis F. DeCraene | December 20 2003 | 6:45 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 5830 Bellanca Drive | Elkridge | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 361-32-7236 | 1 [X] M 2 [ ] F | 61 Yrs. | | | Aug. 28, 1942 | Illinois |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Howard | Elkridge | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5830 Bellanca Drive | 21075 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 5+ | Vice President of Marketing | Erachem Comilog, Inc. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Henry DeCraene | Margaret Roman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Judy DeCraene - Wife | 5830 Bellanca Drive Elkridge, Maryland 21075 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Meadowridge Mem. Park | 12/23/03 | Elkridge, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| M. Poh | Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Boulevard Elkridge, MD 21075 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. GASTRIC CARCINOMA — 4 Months

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Francis X. Strain, III MD | D44715 | 12-22-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCIS X. STRAIN, III MD 301 ST PAUL BALT MD 21202

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar: Amend Item#6perFHG826 12/22/03 EW AMEND ITEM #2&14 PER PHY G829 3/23/04 JR

Reg. No. 2003 41217

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Yerby Dixon

2. Date of Death (Month, Day, Year): DEC 03,2003

3. Time of Death: 9:15 AM

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 108-52-4776

6. Sex: 1 [X] M 2 [ ] F ~~[X]~~

7. Age (In yrs. last birthday): 46 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 5, 1957

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7447 Hickory Log Circle

10f. Zip Code: 21045

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: ~~White~~ BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Musician

16b. Kind of Business/Industry: Music Industry

17. Father's Name (First, Middle, Last): Yerby Alexander Dixon

18. Mother's Name (First, Middle, Maiden Surname): Vivian Loraine Miller

19a. Informant's Name/Relationship (Type, Print): Judie M. Dixon, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7447 Hickory Log Circle Columbia, MD. 21045

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park

Date: 12-9-03

20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive heart failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

renal failure

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 022547

29d. Date signed (Month, Day, Year): December 9, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary Goode 11055 Little Patuxent Columbia Maryland 21044

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Deanna Dunlap
03-7625
AKG

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41218

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Deanna Dunlap | November 28, 2003 | 4:46 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 4623 Asbury Avenue | Baltimore City | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| unk | 1☐ M 2☒ F | 57 Yrs. | | | Jan 2, 1946 | unk |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4623 Asbury Avenue | 21206 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| unk<br>1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☐ No unk<br>If Yes, Give Year or Dates: | 1☐ Yes 2☒ No *Specify:* | *Specify:* black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| unk | unk | unk | unk |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| unk | unk |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| O.C.M.E. | 111 Penn Street Baltimore, MD 21201 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Seizure Disorder

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒ Yes 2☐ No | 1☒ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) At scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | O.C.M.E. | November 29, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41219

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Vicenta | DeRuvo | December 15, 2003 | 2:55 PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2008 Gooseneck Rd. | Pasadena | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| N/A | 1☐ M 2☒ F | Yrs. | | | Feb. 1, 1918 | Italy |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Anne Arundel | Pasadena | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2008 Gooseneck Rd. | 21122 | Italy |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Household |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Miguel DeRuvo | Leonarda Catalano |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Leonarda M. Papa (Daughter) | 2008 Gooseneck Rd. Pasadena, Md. 21122 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | LaPiedad Cemetery | Jan 8,2004 | Rosario, Argentina |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Maryland 21122 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Breast Cancer | 10 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] M.D | D39505 | December 17, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Yvanish Markan 305 Hospital Dr, Glen Burnie, MD. 21061

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2003 41220

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MABEL DAWSON

2. Date of Death (Month, Dey, Year): December 4, 2003

3. Time of Death: 9:30 PM

4a. Facility Name (If not institution, give street end number): Genesis Randallstown

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-30-5349

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): Jan 29, 1924

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 9109 Liberty Road

10f. Zip Code: 21133

10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Educetion (Specify only highest grede completed): Elementary/Secondary (0-12): unk | College (1-4or 5+): unk

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): housekeeping

16b. Kind of Business/Industry: hospital

17. Father's Name (First, Middle, Lest): John Cross

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): John Cross/nephew

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 4010 Woodmere Avenue Baltimore, MD 21215

20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other piece):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. ARRHYTHMIA

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year):

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature end title of certifier: MD

29c. License number: D52360

29d. Date signed (Month, Dey, Year): 12/15/03

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): CUBIR SANDHU 1838 GREENE TREE RD SUITE 300 PIKESVILLE MD 21208

**State Registrar**

31. Dete filed (Month, Dey, Yeer): DEC 22 2003

32. Registrer's Signature:

ORIGINAL

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelth and Mental Hygiana.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41221

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MARY C. ELINE

2. Date of Death — Month: DEC. Dey: 18 Year: 2003

3. Time of Death: 7:50 PM

4a. Facility Name *(If not institution, give street and number)*: LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

**Funeral Director**

5. Social Security Number: 218-09-3181

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 82 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 9-30-1921

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1833 Hanford Rd.

10f. Zip Code: 21237

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*

Elementary/Secondary (0-12): 12 yrs.

College (1-4or 5+): N/A

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: File Clerk

16b. Kind of Business/Industry: Insurance

17. Father's Neme *(First, Middle, Last)*: Thomas O'Rourke

18. Mother's Name *(First, Middle, Maiden Surname)*: Daisy DeBraufre

19a. Informant's Name/Relationship *(Type, Print)*: Michele Eline Stec (Daughter)

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 420 Cedar Springs Rd. Belair, Maryland 21015

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.

Date: 12-22-03

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: E. J. Lassahn

22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Stroke

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Raymond Miller MD

29c. License number: D47683

29d. Date signed *(Month, Day, Yeer)*: 12/19/03

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Raymond Miller 25 Main Street Suite 200 Hunterstown MD

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 22 2003

32. Registrer's Signature

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requiras that tha daath certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral diractor, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

ADH
ROSA ELLIS
03-8108

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41222

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Rosa | Ellis | DECEMBER 16, 2003 | 1907 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 242-60-9602 | 1☐ M 2☒ F | 62 Yrs. | | | 7 28 1941 | N.C. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 401 E. 25th Street Apt. 3F | 21218 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10th | | Domestic | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Warren Ellis | Willette Parks |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lennon E. Ellis-son | 1317 Greenmount Ave., Baltimore, MD 21202 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Mt. Zion Cemetery | 12/20/03 | Baltimore MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Bishop Wade | March Funeral Home-East 1101 E. North Avenue Baltimore, MD 21202 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ~~Hypertensive Arteriosclerotic Cardiovascular Disease~~ Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☒ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | OCME | DECEMBER 20, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary C. Phillips MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41223

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Gwendolyn Eppard | December 21 2003 | 6:30 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| North Arundel Hospital | Glen Burnie, MD | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-42-3412 | 1☐ M 2☒ F | 58 Yrs. | | | July 19, 1945 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Berkley | Martinsburg | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 52 Lunar Way | 25401 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Robert Fittro | Sue Brannen |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Earl H. Eppard, husband | 52 Lunar Way Martinsburg, WV. 25401 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Crestlawn Memorial Gardens | 12-24-03 | Marriottsville, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Rebecca Parker | Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Klebsiella Sepsis | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Deep Venous thrombosis | |
| | Due to (or as a consequence of): | |
| | c. Metastatic Lung Cancer | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Henry L Francis MD | D027415 | 12/21/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
North Arundel Hospital, Glen Burnie, MD.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ Grace L Smith |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41224

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Edward William Eaton Jr. | December 20,2003 | 12:45 a.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Greater Baltimore Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-26-7418 | 1☒M 2☐F | 72 Yrs. | | | August 7,1931 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Timonium | 1☐Yes 2☐No X |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 205 Fountain Court | 21093 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married XX Widowed 4☐Divorced | XX Yes 2☐No If Yes, Give Year or Dates: 1955/57 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Landscaper | State of Maryland |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Edward William Eaton Sr. | Ethel Kauvghn |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Kenneth Wayne West (nephew) | 204 Duke of Kent Apt.104 Cockeysville,Md. 21030 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation XX Other (Specify) Entombent | Dulaney Valley Mausoleum | 12/23/03 | Timonium,Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Robert M. Kratz | Mitchell-Wiedefeld F.H. Inc. 6500 York Rd. Baltimore,Maryland 21212 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute myocardial infarction | one hour |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ John T. Evelius | D0034952 | 12/22/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John T. Evelius MD 7600 Osler Dr. Suite 308 Towson,Maryland 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41225

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Everly
2. Date of Death Month Day Year: DECEMBER 12 2003
3. Time of Death: 814 AM
4a. Facility Name (If not institution, give street and number): SAINT AGNES HOSPITAL CARE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: 162-30-5935
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs. If Under 1 Year: Months Days; If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): July 18, 1937
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Halethorpe
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1112 Courtney Road
10f. Zip Code: 21227
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): printer
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Florence Henry/friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1112 Courtney Road Halethorpe, MD 21227

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — 5 DAYS

Due to (or as a consequence of):
b. ASPIRATION PNEUMONIA — 5 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CHRONIC OBSTRUCTIVE LUNG DISEASE — YEARS

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: P15622
29d. Date signed (Month, Day, Year): December 12, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT PAZ 900 CATON AVENUE BALTIMORE MD 21229

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

EVERLY, ROBERT

Edward D. Emala
03-07333
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41226

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Edward D. Emala | November 18, 2003 | 10:47 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 8729 Lochbend | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| unk | 1 X M 2 ☐ F | 62 Yrs. | | | Sept 24, 1941 | unk |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Towson | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8729 Lochbend | 21204 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| unk<br>1 ☐ Never Married 2 ☐ Married<br>3 ☐ Widowed 4 ☐ Divorced | unk<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | unk | unk |
| unk | unk | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| unk | unk |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| O.C.M.E. | 111 Penn Street Baltimore, MD 21201 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Atherosclerotic Cardiovascular disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease
Chronic alcoholism

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 ☐ No | 1 X Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) at scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Zabiullah Ali | O.C.M.E. | November 19, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ZABIULLAH ALI 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41227

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): MIRIAM FISHER

2. Date of Death: Month December Day 17 Year 2003

3. Time of Death: 8:16 PM

4a. Facility Name (If not institution, give street end number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

5. Social Security Number: 215-05-3676

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 25, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Marion Station

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 6333 Charles Cannon Rd.

10f. Zip Code: 21838

10g. Citizen of What Country?: USA

11. Merital Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12 yrs.

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk

16b. Kind of Business/Industry: Retail

17. Fether's Neme (First, Middle, Last): George Romoser

18. Mother's Name (First, Middle, Maiden Surname): Louise Racob

19a. Informent's Name/Relationship (Type, Print): Diane Funk (Daughter)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 2036 Flintshire Rd. Apt. 102 Balto., Md. 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Gardens of Faith Cemetery

Date: 12-20-2003

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ E. F. Lassahn

22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gastro Intestinal bleeding

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Gastric Ulcer

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

MyoCardial Ischemia

Coronary Artery Disease

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. 2☐ **Medicai Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ Wassim El-Hitti MD

29c. License number: RD 207522

29d. Date signed (Month, Day, Year): December 17, 2003

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dr Wassim El-Hitti 9000 Franklin Square Drive Baltimore, Md 21237

State Registrar

31. Dete filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours eftar death.

To the Funeral Director: After this certificate has been signed by tha attending physician end completely filled in by tha funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Fisher Miriam

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #4b&10c&f PER PHY G826 12/30/03 JH

# Certificate of Death

Reg. No. 2003 41228

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| David Fellin | December 14, 2003 | 8:32 PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 9720 51st Avenue | ~~Hyattsville~~ COLLEGE PARK | Prince Georges |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-54-1241 | 1 X M 2 ☐ F | 55 Yrs. | | | Oct 14, 1948 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince George's | ~~Hyattsville~~ COLLEGE PARK | 1 XX Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9720 51st Avenue | ~~20784~~ 20740 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4 | engineer | U.S. Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Fellin | Masie Phipps |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Marlene Keith/cousin | 8106 Winterpock Road Midlothian, VA 23112 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE MYOCARDIAL INFRCTION | 12-14-03 |
| Due to (or as a consequence of): | b. ATHEROSCLEROTIC HEART DISEASE | 9-29-01 |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. DIABETES MELLITUS Type 2 | 1-1-85 |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| A Hussain MD | D0013668 | 12-16-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AZHER HUSSAIN MD 4917, EDGEWOOD RD. COLLEGE PK. MD. 20740

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41229

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| KURT | FLAMM | DECEMBER 18, 2003 | 9:00 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 6105 BILTMORE AVENUE | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-30-6677 | 1☐M 2☐F X | 93 Yrs. | | | OCT 5, 1910 | GERMANY |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6105 BILTMORE AVE | | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | RABBI | RELIGION |
| | 5+ | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| LEOPOLD FLAMM | YETTCHEN KOENIGSHOEFFER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| RABBI ARI FLAMM/SON | 6105 BILTMORE AVE. BALTIMORE, MD. 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | CHEVRA AHAVAS CHESED | 12/19/2003 | RANDALLSTOWN, MD |

21. Signature of Funeral Service Licensee: Scott M. Cottler

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CARDIO pulmonary ARREST | immediate |
| Due to (or as a consequence of): | b. CARDIOMYOPATHY | 10y |
| Due to (or as a consequence of): | c. ISCHEMIC HEART DISEASE | 20y |
| Due to (or as a consequence of): | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D25034 | 12-18-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Julian Jay Boltz MD 2935 Smith Ave BALTIMORE 21209

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41230

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| MORTON | WILLIAM | FELDMAN | December 17 2003 | 00:18 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-10-6355 | 1 [X] M 2 [ ] F | 81 Yrs. | | | MAY 25, 1922 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | STEVENSON | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8617 KELLER AVE. | 21153 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | LAND DEVELOPER | HOME BUILDING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| HERMAN FELDMAN | FANNIE BILLER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MOSITA FELDMAN (WIFE) | 8617 KELLER AVE. STEVENSON, MD 21153 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) ENTOMBMENT | HAR SINAI | 12/19/03 | OWINGS MILLS, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Scott M. Cottler | SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | 7d |
| Due to (or as a consequence of): | b. Pneumonia | 7d |
| Due to (or as a consequence of): | c. | |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [X] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

preexisting pulmonary disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Matthew J. Weiss | RES-000 | 12/17/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Matthew J. Weiss, MD Sinai Hospital of Baltimore

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

patient known as Morton Feldman

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41231

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILLIAM CHARLES GLADDEN
2. Date of Death (Month, Day, Year): DECEMBER 22, 2003
3. Time of Death: 4:20 AM
4a. Facility Name (If not institution, give street and number): 3403 ORBITAN ROAD
4b. City, Town, or Location of Death: CARNEY
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 216-28-7917
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 16, 1933
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: CARNEY
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3403 ORBITAN ROAD
10f. Zip Code: 21234
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1955-57
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAINTENANCE FOREMAN
16b. Kind of Business/Industry: LOCKE INSULATOR

17. Father's Name (First, Middle, Last): MAURICE C. GLADDEN
18. Mother's Name (First, Middle, Maiden Surname): KATHLEEN A. BURNS

19a. Informant's Name/Relationship (Type, Print): NORA JEAN GLADDEN / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3403 ORBITAN ROAD, CARNEY, MD 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKWOOD CEMETERY Date: DEC. 24, 2003
20c. Location - City or Town, State: PARKVILLE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EVANS FUNERAL CHAPEL 8800 HARFORD RD, PARKVILLE, MD 21234

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Myelofibrosis c bone marrow failure — Approximate Interval Between Onset and Death: 16 yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Gangrene lower extremities s/p transtibial amputation, coronary vascular disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D0010691
29d. Date signed (Month, Day, Year): 12/22/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arthur A Sergent MD St Joseph Med Ctr Towson, Md 21204

**State Registrar**

31. Date filed (Month, Day, Year): DEC 29 2003
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41232

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: PAUL DAVID GREEN

2. Date of Death Month / Day / Year: December 19 2003

3. Time of Death: 1:06 pm

4a. Facility Name *(If not institution, give street and number)*: STELLA MARIS AT MERCY

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: 215 16 6961

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APRIL 3, 1923

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: PA.

10b. County: YORK

10c. City, Town or Location: HANOVER

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8 CARDINAL DRIVE

10f. Zip Code: 17331

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: W.W II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 6 YRS. College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BRAKEMAN

16b. Kind of Business/Industry: B.+O. RAILROAD

17. Father's Name *(First, Middle, Last)*: PAUL GREEN

18. Mother's Name *(First, Middle, Maiden Surname)*: ELMA ROONEY

19a. Informant's Name/Relationship *(Type, Print)*: PAULA DEITHORN

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8 CARDINAL DRIVE HANOVER, PA. 17331

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WESTERN CEMETERY

Date: DEC 22 2003

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE, MARYLAND 312334

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease — years

Due to (or as a consequence of):
b. Hypertension — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Diabetes — years

Due to (or as a consequence of):
d. Congestive Heart Failure — years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thaw Poon, MD, FACP

29c. License number: D 51088

29d. Date signed *(Month, Day, Year)*: Dec 19, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thaw Poon 301 St Paul Place, #701, Baltimore, MD 21202

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 22 2003

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

GREEN, PAUL
**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41233

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Katie | Mae | Garland | 12 | 16 | 2003 | 10:35 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 501 E. Preston Street Apt. 210 | Baltimore | NA |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 200-18-3134 | 1☐ M 2☒ F | 80 Yrs. | | | 12-19-22 | N.C. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | NA | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 501 E. Preston St. Apt. 210 | 21202 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10th grade | | Domestic | Other People Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Arthur Bowden | Irene Bridgers |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jacqueline Noel Daughter | 2108 Moyer St., Baltimore, Md. 21231 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Woodlawn Cem. | 12-22-03 | Baltimore, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gladys Wane | March F.H. East Baltimore, Md. 21202 1101 E. North Ave. |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D37343 | 12/18/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ATHOL MORGAN MD MHS, 2600 LIBERTY HEIGHTS AVE. BALTIMORE MD 21215

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41234

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Garland T. Galliher | December 16, 2003 | 2:26 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Greater Baltimore Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 227-22-3853 | 1☒M 2☐F | 78 Yrs. | | | April 11,1925 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Edgewood | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1932 Sidnee Drive | 21040 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1943-45 WWII | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 Years | | Welder | Steel Industry |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Mack Galliher | Bertha Turner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Roberta Galliher (Wife) | 1932 Sidnee Drive Edgewood, Maryland 21040 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Crownsville V.A. Cem. | 12/19/2003 | Crownsville, MD |

21. Signature of Funeral Service Licensee: ▶ Dan C. Carroll

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PNEUMONIA | 1 week |
| | Due to (or as a consequence of): | |
| | b. LYMPHOMA | 1 MONTH |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | 053430 | DECEMBER 17 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRED CHAN 6701 NORTH CHARLES STREET BALTIMORE MARYLAND 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ Brenda B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Victoria Lynn Grammer
03-08177
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Unpend Item #23a,27,28a-f per mc 1/29/04 sas

# Certificate of Death

Reg. No. 2003 41235

2837

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Victoria Lynn Grammer
2. Date of Death (Month, Day, Year): December 19, 2003
3. Time of Death: 5:16 P M
4a. Facility Name (If not institution, give street and number): Harbor Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A
5. Social Security Number: 218-84-0751
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 41 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 17, 1962
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7518 Biscayne Bay Blvd.
10f. Zip Code: 21220
10g. Citizen of What Country?: USA
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. College (1-4or 5+): 2 yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant
16b. Kind of Business/Industry: Dental
17. Father's Name (First, Middle, Last): John Grammer
18. Mother's Name (First, Middle, Maiden Surname): Isabelle Watt
19a. Informant's Name/Relationship (Type, Print): John Grammer father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7518 Biscayne Bay Blvd. Chase Md. 21220
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: Dec. 22, 2003
20c. Location - City or Town, State: Baltimore
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Bupropion Intoxication

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☑ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? X 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): Found 12/19/03
28b. Time of Injury: Found 4:00 P M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject ingected drug
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found at home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1404 Filbert St. Baltimore, Md.

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 20, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

OK 2nd DIST (1)

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41236

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Margaret | Elizabeth | Greaves | December 15 2003 | 2:08 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Agnes Health Care | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-09-1223 | 1☐M 2☒F | 84 Yrs. | | | July 12, 1919 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Halethorpe | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4333 Ridge Avenue | 21227 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Archie Hoxter | Addison Joseph Forman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| James A. Greaves (Son) | 4333 Ridge Ave., Halethorpe, MD 21227 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Stevensville Cemetery | 12/18/03 | Stevensville, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Loudon Park Funeral Home, 3620 Wilkens Ave., Baltimore, MD 21229

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Respiratory Failure | 4 hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Myocardial Infarction | 24 Hours |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Rachel Thomas MD | P15627 | December 15 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rachel Thomas 900 Caton Ave Baltimore MD 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | [signature] |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Margaret Greaves

6

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM @!&22 PER DVR

# Certificate of Death

Reg. No. 2003 41237

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Timothy Ronald Glacken, II
2. Date of Death Month Day Year: DECEMBER 13 2003
3. Time of Death: 0248
4a. Facility Name (If not institution, give street and number): THE MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

**Funeral Director**

5. Social Security Number: N/A
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 0 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours 1 / Min. 8
8. Date of Birth (Month, Day, Year): 12-13-03
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11952 Cordova Rd
10f. Zip Code: 21625
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Timothy Ronald Glacken
18. Mother's Name (First, Middle, Maiden Surname): Christy Marie Ballard

19a. Informant's Name/Relationship (Type, Print)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11952 Cordova Rd, Cordova, MD 21625

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): State Anatomy Board — Date: 12/13/03
20c. Location - City or Town, State: Easton, MD

21. Signature of Funeral Service Licensee: ~~N/A~~ RONALD S. WADE, DIRECTOR PER DVR
22. Name and Address of Facility: ~~N/A~~ STATE ANATOMY BOARD 655 W. BALTIMORE ST. BALTO, MD.

**To Be Completed by Funeral Director**

GLACKEN BABY BOY

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. extreme prematurity
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to tha causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? N/A 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) N/A

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): N/A
28b. Time of Injury: N/A M
28c. Injury at Work? N/A 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred: N/A
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A
28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elizabeth H. Mason MD
29c. License number
29d. Date signed (Month, Day, Year): 12/14/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elizabeth H. Mason c/o Dutchmans Lane Easton MD 21601

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41238

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): SARAH GERSCH
2. Date of Death (Month, Day, Year): Dec 11 2003
3. Time of Death: 8:15 PM
4a. Facility Name (If not institution, give street and number): LEVINDALE HEBREW HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-09-7970
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 29 1908
9. Birthplace (State or Foreign Country): MD.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2434 WEST BELVEDERE AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 2 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLAIMS ADJUSTER
16b. Kind of Business/Industry: INSURANCE

17. Father's Name (First, Middle, Last): MORRIS BRODSKY
18. Mother's Name (First, Middle, Maiden Surname): FANNIE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): MRS. MARSHA ROBINSON/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1282 HUMBERT SCHOOLHOUSE RD WESTMINSTER,MD.21158

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD. VETERANS
Date: 12/19/2003
20c. Location - City or Town, State: OWINGS MILLS,MD.

21. Signature of Funeral Service Licensee: Jos J Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD.21208

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Dementia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia
Depression
Chronic Anemia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D
29c. License number: D56508
29d. Date signed (Month, Day, Year): Dec 12 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2434 W Belvedere Ave, Baltimore, MD 21215

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

GERSCH, SARAH

5

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41239

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last) JANE CAROL HALES

2. Date of Death (Month, Day, Year) DECEMBER 21 2003

3. Time of Death 912 PM

4a. Facility Name (If not institution, give street and number) 828-A WIND STREAM WAY

4b. City, Town, or Location of Death EDGEWOOD, Md 21014

4c. County of Death HARFORD

**Funeral Director**

5. Social Security Number 218-52-0174

6. Sex 1☐ M 2☒ F

7. Age (In yrs. last birthday) 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year) OCT. 20, 1938

9. Birthplace (State or Foreign Country) MARYLAND

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State MARYLAND

10b. County HARFORD

10c. City, Town or Location EDGEWOOD

10d. Inside City Limits 1☐ Yes 2☒ No

10e. Street and Number 828 WIND STREAM WAY APT A.

10f. Zip Code 21040

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9 YRS.

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DISABLED

16b. Kind of Business/Industry UNEMPLOYED

17. Father's Name (First, Middle, Last) JOSEPH G. HALES, SR

18. Mother's Name (First, Middle, Maiden Surname) MAE E. MUMMA

19a. Informant's Name/Relationship (Type, Print) JOSEPH G. HALES, JR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 DOGWOOD DR COURT EDGEWOOD MARYLAND 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) OLIVET VALLEY

Date: Dec. 24, 2003

20c. Location - City or Town, State TIMONIUM, MARYLAND 21234

21. Signature of Funeral Service Licensee

22. Name and Address of Facility EVANS & HAREL OF MEMORIES 3800 HARFORD ROAD PARKVILLE, MARYLAND

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

NONE

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician.** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bernard J. Yukna MD, DME

29c. License number: D0014206

29d. Date signed (Month, Day, Year): December 21, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERNARD J. YUKNA MD, DME 7018 HOLABIRD AVE BALTO MD 21222

**State Registrar**

31. Date filed (Month, Day, Year) DEC 22 2003

32. Registrar's Signature

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#1perPHYG826 12/22/03 EW

# Certificate of Death

Reg. No. 2003 41240

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ~~LAURA HENRY HARDY~~ Laura Hardy Henry

2. Date of Death: Month 12 Day 08 Year 03

3. Time of Death: 4:30pm

4a. Facility Name (If not institution, give street and number): SPRING GROVE HOSPITAL CENTER

4b. City, Town, or Location of Death: CATONSVILLE

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 218-48-2063

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 25 1945

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 55 Wade Ave

10f. Zip Code: 21228

10g. Citizen of What Country: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): 5yrs+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator

16b. Kind of Business/Industry: Coppin State College

17. Father's Name (First, Middle, Lest): Willie Arthur Hardy

18. Mother's Name (First, Middle, Maiden Sumame): Ella Lee Hawkins

19a. Informant's Name/Relationship (Type, Print): Patricia Hardy Stark-Sister

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 12 Millstone Road, Randallstown, Md 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Md National Park

Date: 12/13/03

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Cynthia March Malloy

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. BREAST CANCER — 27 YRS

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T. Ndaki M.D.

29c. License number: D53127

29d. Date signed (Month, Day, Yeer): 12-08-03

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): TIMOTHY M. NDAKI, M.D.; SPRING GROVE HOSPITAL CENTER, CATONSVILLE

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41241

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: John Hawkins

2. Date of Death: Month 12 Day 18 Year 2003

3. Time of Death: 11:50 AM

4a. Facility Name *(If not institution, give street end number)*: Baltimore VAMC 10 N. Greene St.

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 219-50-1326

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAR. 3, 1948

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 751 W. SARATOGA STREET #420

10f. Zip Code: 21201

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1967-1969

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* AFRICAN AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MOVER/LABORER

16b. Kind of Business/Industry: ACE MOVING CO.

17. Father's Name *(First, Middle, Last)*: FRIZ LIPSCOMB

18. Mother's Name *(First, Middle, Maiden Surname)*: GOLDIE HAWKINS

19a. Informant's Name/Relationship *(Type, Print)*: RONALD J. HAWKINS (BROTHER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 529 N. BRICE STREET BALTIMORE, MD 21223

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GARRISON FOREST

Date: 12/31/03

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Respiratory Distress Syndrome

Due to (or as a consequence ot):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Sepsis

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: R. Schraeder, MD

29c. License number: P15905

29d. Date signed *(Month, Day, Yeer)*: 12/18/03

30. Name end eddress ot person who completed cause of death (Item 23e) (Type, Print): Richard Schraeder Baltimore VA 10 N Greene St, Baltimore MD 21201

**State Registrar**

31. Dete filed *(Month, Day, Year)*: DEC 22 2003

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4 of 4

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 24a PER VERB G826 12/22/03 JH *Certificate of Death*

Reg. No. 2003 41242

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Thomas Method Holland

2. Date of Death Month December Day 10 Year 2003

3. Time of Death: 2:50 pm

4e Facility Name *(If not institution, give street end number)*: 203 Kerria Lane

4b. City, Town, or Location of Death: Baltimore County

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212 20 0055

6. Sex: 1☐M 2☐F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: December 14 1924

9. Birthplace *(State or Foreign Country)*: Baltimore, Maryland

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐Yes 2☐No

10e. Street end Number: 203 Kerria Lane

10f. Zip Code: 21220

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Yeer or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☐No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): NA

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Display Artist

16b. Kind of Business/Industry: B.G. & E.

17. Fether's Neme *(First, Middle, Last)*: Method Smith Holland

18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Würm

19e. Informant's Neme/Reletionship *(Type, Print)*: Elizabeth Holland

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 203 Kerria Lane Baltimore, Maryland 21220

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Metro Crematory Inc. Date: December 11 2003

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Charles Lassahn Chojnacki

22. Name and Address of Fecility: Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert fai ire. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death) a. METASTATIC LUNG CANCER — 6 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes cese referred to medicel exeminer? 1☐Yes 2☒No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Menner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and manner es stated. 2☐**Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Geo E Lowe MD

29c. License number: D20673

29d. Date signed *(Month, Dey, Year)*: 12-11-03

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): George Lowe MD 7672 Belair Rd Baltimore, MD 21236

**State Registrar**

31. Dete filed *(Month, Dey, Yeer)*: DEC 22 2003

32. Registrar's Signature

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter deeth.

To the Funeral Director: After this certificete hes been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use es the buriel-transit permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

**Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

ORIGINAL

Robert Hollenbach
03-08088
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM 23a,27&28a-f PER ME G826 12/23/03 JH

# Certificate of Death

Reg. No. 2003 41243

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Robert Hollenbach | December 16, 2003 | 5:15 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 412 Walnut Street | Cumberland | Allegany |

**Funeral Director**

2838

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 227-78-5989 | X 1 M 2 F | 52 Yrs. | | | OCT 7, 1951 | Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Allegany | Cumberland | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 415 Furnace Avenue | 21502 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| X 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: X | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Carpenter | General Contracting |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Thomas Hollenbach | Janet Louise Collins |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John Edwin Hollenbach/Brother | 5279 Club Head Road Virginia Beach, VA 23455 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Metro Crematory Inc. | 12-19-03 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Dawn F. McDonald Dawn F. McDonald | Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC and ETHANOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 X Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 X Other (Specify) at scene

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 XX Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| found 12/16/03 | found 5:00a M | 1 Yes 2 XX No | UNKNOWN |

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify): FOUND AT HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 412 WALNUT ST. CUMBERLAND,MD.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. X 2 **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Patricia Aronica Pollak MD | O.C.M.E. | December 17, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PATRICIA ARONICA POLLAK MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ Teresa K Smith |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20K Fee

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41244

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ralph Meredith Howard, Sr.

2. Date of Death Month Day Year: December 18, 2003

3. Time of Death: 1004 AM

4a. Facility Name (If not institution, give street and number): St. Agnes Healthcare

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 220-14-9535

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV 8, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Linthicum Heights

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 457 Mary Kay Court

10f. Zip Code: 21090

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: General Contracting

17. Father's Name (First, Middle, Last): Taylor Howard

18. Mother's Name (First, Middle, Maiden Surname): UNK.

19a. Informant's Name/Relationship (Type, Print): Ralph Meredith Howard, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 457 Mary Kay Court Linthicum Heights, MD 21090

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 12-19-03

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — Approximate Interval: UNKNOWN

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0051865

29d. Date signed (Month, Day, Year): DECEMBER 18, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES CURTIS ST AGNES HOSPITAL BALTIMORE

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Howard, Ralph

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41245

JANE, HERMANN
Baltimore, Maryland 21215-0036

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JANE WICKHAM HERMANN | December 21, 2003 | 08:24 p.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Greater Baltimore Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-05-5516 | 1☐ M 2☒ F XXX | 86 Yrs. | | | July 4,1917 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Towson | 1☐ Yes 2☒ No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7925 York Road | 21204 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed XX 4☐ Divorced | 1☐ Yes 2☒ No XX If Yes, Give Year or Dates: | 1☐ Yes 2☒ No XX Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Garnet Wickham | Mary Ellen Hayden |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John E Hermann Son | 6002 Pinehurst Road Baltimore, Maryland 21212 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) XX | Dulaney Valley MemGar | 12/23/03 | Timonium Maryland |

21. Signature of Funeral Service Licensee: Dennis Stephen Xenakis

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Chronic obstructive Pulmonary disease | 5 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? M 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Timothy Jiang MD | D54967 | 12/22/3 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Timothy Jiang 6701 N charles st, Baltimore, MD 21204

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | Laura D. Sparks |

**State Registrar**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41246

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANNETTE HURT
2. Date of Death (Month, Day, Year): DEC 20 2003
3. Time of Death: 1605 PM
4a. Facility Name (If not institution, give street and number): Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 241-52-1567
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 23, 1935
9. Birthplace (State or Foreign Country): NC.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 106 N. Luzerne Avenue
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 years
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Officer
16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): John Henry Smith
18. Mother's Name (First, Middle, Maiden Surname): Jessie Bell Hammonds

19a. Informant's Name/Relationship (Type, Print): Gail Gemmill daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 613 S. 47th Street, Dundalk, Md. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cemetery
Date: December 24, 2003
20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — 2 WKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Costa, MD
29c. License number: D42634
29d. Date signed (Month, Day, Year): DEC 20, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH COSTA, MD 301 ST PAUL PLACE BALTIMORE, MD 21201

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

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**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

ADH
NANNIE HARRIS
03-03-8045

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM 23a&27 PER ME G827 1/12/04 JH

# Certificate of Death

Reg. No. 2003 41247

2839

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| NANNIE Harris | DECEMBER 14, 2003 | 0942 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 99 CHARLES STREET | WESTMINSTER | CARROLL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-58-4289 | 1 M 2 X F | 93 Yrs. | | | 8 4 10 | SC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Randallstown, MD | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3831 Rayton RD | 21133 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | None | N/A |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Luther Harris | Lethia DRAKford |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Margret Goins | 2601 E. Hoffman st Balto Md 21213 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Mt Carmel | Dec 19, 03 | Balto MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Ronald G Grayson | Ronald A. Grayson Funeral Home 188 W. North ave, Balto, Md 21201 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PNEUMONIA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 No | 1 X Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 X Other (Specify) AT SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | OCME | DECEMBER 15, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar AMEND ITEM #30 & #26 PER VERB G826 12/22/03 TH

# State of Maryland / Department of Health and Mental Hygiene
# Certificate of Death

Reg. No. 2003 41248

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): RALPH M. HARRISON
2. Date of Death Month Day Year: 12-18-2003
3. Time of Death: 10:37 AM
4a. Facility Name (If not institution, give street and number): 212 AIGBURTH AVENUE
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 214-22-3614
6. Sex: XX 1 M 2 F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09-19-1925
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: BALTIMORE
10c. City, Town or Location: TOWSON
10d. Inside City Limits: 1 Yes XX No
10e. Street and Number: 212 AIGBURTH AVENUE
10f. Zip Code: 21286
10g. Citizen of What Country?: U. S. A.

11. Marital Status: XX 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX 1 Yes 2 No If Yes, Give Year or Dates: 1950-1952
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): REPAIRMAN
16b. Kind of Business/Industry: APPLIANCES

17. Father's Name (First, Middle, Last): GEORGE STANLEY HARRISON
18. Mother's Name (First, Middle, Maiden Surname): CAROLINE CATHERINE GRAHAM

19a. Informant's Name/Relationship (Type, Print): DOROTHY E. JONES (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3121 HISS AVENUE, PARKVILLE, MARYLAND, 21234

20a. Method of Disposition: 1 Burial XX Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HILLTOP SERVICE CORP. | Date: 12-19-2003
20c. Location - City or Town, State: TOWSON, MD.,21204

21. Signature of Funeral Service Licensee: ▶ R. H. Ruck
22. Name and Address of Facility: RUCK TOWSON FUNERAL HOME, INC. 1050 YORK ROAD TOWSON,MD.21204

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerebral Palsy
Congestive Heart Failure
Hypertension

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ☑ No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes XX No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes XX No
26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ~~ER~~/Outpatient 3 DOA | Other: 4 Nursing Home 5 XX Residence 6 Other (Specify)

27. Manner of Death: XX 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): XX 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ John F. Marra M.D.
29c. License number: D25075
29d. Date signed (Month, Day, Year): DECEMBER 18, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. JOHN MARRA 5601 LOCH RAVEN BLVD TOWSON,MD.

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature: ▶

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41249

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dennis S. Harris

2. Date of Death: Month: December Day: 13 Year: 2003

3. Time of Death: 4:19 am

4a. Facility Name (If not institution, give street and number): Stella Maris Mercy Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 218-58-2662

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-26-52

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Md

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 3532 Cottage Ave

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 9/70-5/76

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Packer

16b. Kind of Business/Industry: Food Service

17. Father's Name (First, Middle, Last): Melvin Harris

18. Mother's Name (First, Middle, Maiden Surname): Lucille Bushrod

19a. Informant's Name/Relationship (Type, Print): Wife Valerie Harris

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3532 Cottage Ave Balto. MD. 21215

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baywood Crematory

Date: 12/19/03

20c. Location - City or Town, State: Balto. MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Miller's Metropolitan Chapel 1639 N. Broadway 21213

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Anoxic Encephalopathy
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Hospice

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D07930

29d. Date signed (Month, Day, Year): December 15, 2003

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Marvin J. Feldman 301 St. PAUL PL. Baltimore MD. 21202

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature: [signature]

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41250

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Virginia B. Helmuth | December 11, 2003 | 9:55 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 8800 Walther Blvd #1505 | Baltimore | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-07-8417 | 1☐ M 2☒ F | 86 Yrs. | | | Mar 29, 1917 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Baltimore | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8800 Walther Blvd #1505 | 21234 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 3 | homemaker | own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Bird Bowen | Ethel Cummings |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Craig B. Helmuth/son | 2115 Buell Drive Fallston, MD 21047 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify) | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute myeloid leukemia | 3 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| William M. Russell | D30182 | December 16, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William M. Russell 8800 Walther Blvd Baltimore MD 21234

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2003 41251

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Luther Hood
2. Date of Death (Month, Day, Year): December 13, 2003
3. Time of Death: 7:32 PM
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 238-30-8903
6. Sex: 1 [X] M 2 [ ] F
7. Age (If Yrs. last birthday): 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 9, 1910
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 257 S. Dallas Court
10f. Zip Code: 21231
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): grave digger
16b. Kind of Business/Industry: cemeteries

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Geraldine Cannon/step daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1306 Spring Street Baltimore, MD 21202

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — Approximate Interval Between Onset and Death: Two days

Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes, Type II
Cerebrovascular Disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physicien:** To the best of my knowledge, death occurrad at tha time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Qinglin Gao, MD
29c. License number: D0059855
29d. Date signed (Month, Day, Year): December 16, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Qinglin Gao, MD 5601 Loch Raven Boulevard, Baltimore 21239

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41252

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): IRENE G. JENNINGS
2. Date of Death Month/Day/Year: 12-20-03
3. Time of Death: 6:25 AM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-34-2914
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 3, 1937
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: WHITE MARSH
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 4946 BRIGHTLEAF COURT
10f. Zip Code: 21237
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 13 YRS.
College (1-4or 5+): 2 YRS.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): administration
16b. Kind of Business/Industry: EASTPOINT MEDICAL CENTER

17. Father's Name (First, Middle, Last): JOHN E. GRIMES
18. Mother's Name (First, Middle, Maiden Surname): CATHERINE CUMBERLAND

19a. Informant's Name/Relationship (Type, Print): JOHN W. JENNINGS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4946 BRIGHTLEAF COURT WHITE MARSH, MARYLAND 21237

20a. Method of Disposition: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARDENS OF FAITH
Date: Dec 23 2003
20c. Location - City or Town, State: ROSEDALE, MARYLAND

21. Signature of Funeral Service License: [signature]
22. Name and Address of Facility: EVANS HARRIS MEMORIAL 2800 HARFORD ROAD PARKVILLE, MARYLAND 21234

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Intraabdominal Sepsis — 48hrs
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Perforated intraabdominal viscous — 48 hrs
Due to (or as a consequence of):
c. Lung Cancer — 6 months
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month/Day/Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Breast Cancer

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D0060453
29d. Date signed (Month, Day, Year): December, 20, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Anastasios Saliaris, 9000 Franklin Square Drive Baltimore, Md. 21237

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Jennings, Irene
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#5, per FH, G827, 01/09/04, CC **Certificate of Death** Reg. No. 2003 41253

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dorothy V. Judy.
2. Date of Death: Month DEC Day 17 Year 2003
3. Time of Death: 2 PM
4a. Facility Name (If not institution, give street and number): Good Samaritan Nursing Ctr.
4b. City, Town, or Location of Death: Baltimore.
4c. County of Death:

**Funeral Director**

5. Social Security Number: ~~218-09-2794~~ ~~218-07-2039~~
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 85 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): 12-15-18
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7819 Westmoreland Ave
10f. Zip Code: 21234
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Beautician
16b. Kind of Business/Industry: Beauty Shop

17. Father's Name (First, Middle, Last): George J. Haslup.
18. Mother's Name (First, Middle, Maiden Surname): Mabel E. Krause.

19a. Informant's Name/Relationship (Type, Print): Darlene L. Sicca
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1232 Whispering Woods Way, Bel Air, MD 21014.

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Mem. Park Date: 12-20-03
20c. Location - City or Town, State: PARKVILLE, MD

21. Signature of Funeral Service Licensee: Kimberly A. Zuttah
22. Name and Address of Facility: BALTIMORE, MD 21234. EVANS FUNERAL CHAPEL, 8800 HARFORD RD.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial infarction — Approximate Interval: immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D52583
29d. Date signed (Month, Day, Year): 12/19/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Sperling, 5601 Loch Raven Blvd., Baltimore MD 212

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41254

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HAROLD JOHNSON

2. Date of Death: Month DECEMBER Day 14 Year 2003

3. Time of Death: 15 20 PM

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM

4b. City, Town, or Location of Death: BALTIMORE, MARYLAND

4c. County of Death:

**Funeral Director**

5. Social Security Number: 111-20-3498

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 16, 1930

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2311 Roslyn Avenue

10f. Zip Code: 21216

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [XX] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unknown

16b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): Harold A. Johnson, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Hazel F. Williams

19a. Informant's Name/Relationship (Type, Print): Alfred McEwen (Brother-in-law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1292 Sheridan Road, Crownsville, MD 21032

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 12/17/2003

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 RidgelyAvenue, Annapolis, MD 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. RESPIRATORY INSUFFICIENCY

Due to (or as a consequence of):

b. METABOLIC ACIDOSIS

Due to (or as a consequence of):

c. RENAL FAILURE

Due to (or as a consequence of):

d. AORTIC DISSECTION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MINIMAL BRAIN ACTIVITY

METABOLIC DISORDER

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD (SURGERY RESIDENT)

29c. License number: P16547

29d. Date signed (Month, Day, Year): DECEMBER 17, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 49 MUSGROVE COURT BALTIMORE, MARYLAND 21236

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 17 Rev 1/2001

ORIGINAL

Julia Johnson
03-08043
RPD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **Unpend Item#23a,27,Per ME,G828,2/27/04eg** *Certificate of Death* Reg. No. 2003 61255

2840

**Physician /Medical Examiner** | **Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|---|
| Julia | Johnson | December 14, 2003 | 0802 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Maryland General Hospital | Baltimore | NA |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-62-7700 | 1 M 2 X F | 49 Yrs. | | | 5-23-54 | S.C. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | NA | Baltimore | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2310 Mt. Royal Terrace | 21217 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 X Widowed 4 Divorced | 1 Yes 2 No If Yes, Give Year or Dates: X | 1 Yes 2 X No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | | Baggage Check | Amtrak |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Johnson | Doray Jordan |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Billy Booker Friend | 2310 Mt. Royal Terr., Baltimore, Md. 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | King Mem. Pk. | 12-20-03 | Randallstown, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gladys Warner | March F.H. East Baltimore, Md. 21202 1101 E. North Ave. |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. **Infective Endocarditis**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 Yes 2 No 9 X Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 No | 1 X Yes 2 No |

25. Was case referred to medical examiner? X Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 X DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| X 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Theodore M. Kiggins | O.C.M.E. | December 15, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE Mcking 111 Penn Street, Baltimore, Maryland 21201

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ Barbara D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41256

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Pauline Grace Jager
2. Date of Death (Month, Day, Year): 12/16/2003
3. Time of Death: 5:50 A M
4a. Facility Name (If not institution, give street and number): 1510 Stone Rd.
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 215-22-6751
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/11/1913
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Finksburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2258 Baltimore Blvd
10f. Zip Code: 21058
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dietician
16b. Kind of Business/Industry: Healthcare

17. Father's Name (First, Middle, Last): Walter Nicholas Bruno
18. Mother's Name (First, Middle, Maiden Surname): Grace Frances Beal

19a. Informant's Name/Relationship (Type, Print): Norma Nelson / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2258 Baltimore Blvd Finksburg, MD 21058

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lorraine Park
Date: 12/19/2003
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: Sean P. Shubert
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Maryland 21227

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Dementia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic coronary vasc. disease.
HTN

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Domestary care.

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Philip Ruzbarsky MD
29c. License number: D33599
29d. Date signed (Month, Day, Year): 12-17-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Philip Ruzbarsky M.D. 125 Airpark Drive Westminister, Maryland 21157

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Pauline G. Jager

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41257

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Janice R. Judd
2. Date of Death Month / Day / Year: 12 / 19 / 2003
3. Time of Death: 6:00 pm
4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 484 18 4006
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs, last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 8 1919
9. Birthplace *(State or Foreign Country)*: Iowa

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Edgemere
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2825 Lodge Farm Rd.
10f. Zip Code: 21219
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Ray Samuel Roush
18. Mother's Name *(First, Middle, Maiden Surname)*: Elsie Clair Barker

19a. Informant's Name/Relationship *(Type, Print)*: Steve Judd / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2605 Waterfront Rd. Edgemere MD. 21219

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bayview Crematory | Date: Dec. 20 2003
20c. Location - City or Town, State: Baltimore, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Pt. Rd. Dundalk, MD 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Influenza
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure, Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: RES 0000
29d. Date signed *(Month, Day, Year)*: 12-19-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Priyanka Jain 9000 Franklin Square Dr. Baltimore, Md 21237

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 22 2003
32. Registrar's Signature: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41258

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Edward Jones | December 13 2003 | 8:35 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Agnes Health Care | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-40-7735 | 1 ☒ M 2 ☐ F | 60 Yrs. | | | 9-21-43 | Md. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md | | Balto. | 1 ☒ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5028 Pinridge Rd. | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Counselor | Private |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Edward Jones Sr. | Florence Waters |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Valerie Jone Daughter | 3020 Baker st. Balto. Md. 21216 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Bayview | 12-24-03 | Dundalk Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Wesley Chavis Jr. | Wesley Chavis Jr. Funeral Home 2009 Eastern Ave. Balto. Md 2123 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia with respiratory failure | 2 wks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Chronic obstructive pulmonary disease | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Human immunodeficiency virus infection

Cytomegalovirus infection

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown | 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Nanjamma (M.D.) | AS-0243528 | 12/13/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nirupama Mitikiri, St Agnes Health Care, 900 Caton Ave, Baltimore MD 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

JONES, EDWARD

Columbus Abraham Jackson
03-7837
AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 5,9,11,12,15,16a-b per attorney G836 10-13-04 tas

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41259

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Columbus Abraham Jackson
2. Date of Death (Month, Day, Year): December 6, 2003
3. Time of Death: 2:21 PM
4a. Facility Name (If not institution, give street and number): 1311 South Philadelphia Boulevard #2
4b. City, Town, or Location of Death: Aberdeen
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: ~~unk~~ 433-54-2407
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 29, 1937
9. Birthplace (State or Foreign Country): ~~unk~~ LA

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1311 S. Philadelphia Blvd
10f. Zip Code: 21001
10g. Citizen of What Country: USA

11. Marital Status: ~~unk~~ 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No ~~unk~~ If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): ~~unk~~ 12
College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ~~unk~~ SFC Retired
16b. Kind of Business/Industry: ~~unk~~ U.S.Army

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): O.C.M.E.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 Penn Street Baltimore, MD 21201

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b.
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CANCER OF THROAT

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [XX] Other (Specify) At scene

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Wayne Dorschell MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 7, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANNA A. KOREL 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41260

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ruth Krebs
2. Date of Death (Month, Day, Year): December 14 03
3. Time of Death: 5:13A M
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 216-20-3327
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 28, 1925
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3106 DUBOIS AVENUE
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): POLICY WRITER
16b. Kind of Business/Industry: INSURANCE

17. Father's Name (First, Middle, Last): JOSEPH J. COSTELLO
18. Mother's Name (First, Middle, Maiden Surname): HAZEL A. HARBACK

19a. Informant's Name/Relationship (Type, Print): JOHN L. KREBS III / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3106 DUBOIS AVE., PARKVILLE, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKWOOD CEMETERY Date: DEC. 17, 2003
20c. Location - City or Town, State: PARKVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Kimberly J. Sagerholm
22. Name and Address of Facility: EVANS FUNERAL CHAPEL 8800 HARFORD RD, PARKVILLE, MD 21234

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last: b. Urinary Tract infection

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Qinglin Gao, MD
29c. License number: D0059855
29d. Date signed (Month, Day, Year): December 16, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Qinglin Gao, MD 5601 Loch Raven Boulevard, Baltimore 21239

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41261

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Baby Boy | Safiatou | Kone | December 10 2003 | 0609 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | NA |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (If yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-67-4568 | 1 [X] M 2 [ ] F | Yrs. | 2 / 4 | | 10-15-03 | Md. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | NA | Baltimore | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1048 N. Eden St. | 21205 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| NA | | Infant | NA |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| UNKN | Safiatou Kone |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Modibo Diallo uncle | 1725 W. Lombard St., Baltimore, Md. 21223 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Mt. Zion Cem. | 12-18-03 | Lansdowne, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gladys Warner | March F.H. East Baltimore, Md. 21202 1101 E. North Ave. |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Necrotizing Enterocolitis | 6 hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Extreme Prematurity | 55 days |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Distress Syndrome; Chronic Lung Disease
Sepsis; Osteomyelitis
Intraventricular Hemorrhage

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [X] No |

| 25. Was case referred to medical examiner? | 26. Place of Death Check on one | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | Res-000 | December 10, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Megan Partridge 600 North Wolfe Street Baltimore, MD 21287-3200

**State Registrar**

| 31. Date Filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41262

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

| | | | | |
|---|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
| Elsie | Virginia | King | December 15 2003 | 11:30pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1824 Chilton Street | Baltimore | |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 228-42-8638 | 1☐ M 2☒ F | 75 Yrs. | | | 09 17 28 | VA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1824 Chilton Street | 21218 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married ☒☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9th grade | na | Environmental Technician | Constr. Corp. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Octavious Jones | Eliza Day |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Genevieve Nichols-Daughter | 1824 Chilton Street Baltimore Md 21218 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | King Memorial Park | 12/22/03 | Randallstown, Md |

21. Signature of Funeral Service Licensee: Debra E Ross

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | 6 mos |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Diabetes types II | yrs |
| | c. Due to (or as a consequence of): Hypertension | yrs |
| | d. Due to (or as a consequence of): severe Peripheral Vascular Disease | yrs |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hepatitis A, Hyperlipidemia gastroparesis, Cerebrovascular Accident with dysarthria

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allen Reilly MD

29c. License number: D54749

29d. Date signed (Month, Day, Year): 12 18 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen Reilly, MD 4805 Benson Ave, Baltimore, MD

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Connor Klienback
03-08137
RPD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM #23a,27&28a-f PER ME G827 1/21/04 JH

# Certificate of Death

Reg. No. 2003 41263

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Connor Logan Klienback | December 18, 2003 | 0631 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Harford Memorial Hospital | Havre de Grace | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| N/A | 1 XX M 2 ☐ F | Yrs. | 2 | | October 17, 2003 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Aberdeen | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 18 Delaware Court | 21005 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| N/A | | N/A | N/A |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Donald W. Klienback | Christa L. Walker |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Donald W. Klienback/Father | 18 Delaware Court Aberdeen Maryland 21005 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | B.G. Wm. C. Doyle UMC. | 12/23/03 | Arneytown New Jersey |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Christina L. Hilton ▶ Christina L. Hilton | Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SUDDEN UNEXPLAINED DEATH IN INFANCY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 ☐ No | 1 X Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 XX Could not be determined | found 12-18-03 | unk M | 1 ☐ Yes 2 XX No | UNKNOWN |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND AT RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State) 10 DELAWARE CT ABERDEEN PROVING GROUND ,MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Ling Li, M.D | O.C.M.E. | December 19, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LING LI, M.D 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

03-08122
JOHN A KOCHAN
WHM

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41264

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John A. Kochan
2. Date of Death (Month, Day, Year): DECEMBER 17, 2003
3. Time of Death: 1:58 P M
4a. Facility Name (If not institution, give street and number): 501 PROSPECT BLVD
4b. City, Town, or Location of Death: FREDERICK CITY
4c. County of Death: FREDERICK CO

**Funeral Director**

5. Social Security Number: 156-52-2227
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 46 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): October 12, 1957
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 501 Prospect Blvd. Apt 9C
10f. Zip Code: 21705
10g. Citizen of What Country?: USA
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unknown
16b. Kind of Business/Industry: Shipping
17. Father's Name (First, Middle, Last): John A. Kochan Sr.
18. Mother's Name (First, Middle, Maiden Surname): Eleanor Samolyk
19a. Informant's Name/Relationship (Type, Print): John A. Kochan, Sr./Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1907 Bay Boulevard Lavallette NJ 08735
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Gertrude Cemetery
Date: 12/22/03
20c. Location - City or Town, State: Colonia New Jersey
21. Signature of Funeral Service Licensee: Christina L. Hilton — Christina L. Hilton
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Contact Gunshot Wound of Head
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No
26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE
27. Manner of Death 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): Found 12/17/03
28b. Time of Injury: Unknown M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Self Inflicted Gunshot Wound
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 4C Apartment 9C 501 Prospect Boulevard Frederick Maryland

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Theodore M. Kenyon
29c. License number: O C M E
29d. Date signed (Month, Day, Year): DECEMBER 18, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore M. Kenyon 111 Penn Street, Baltimore, Maryland 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM #5 PER FH G826 12/22/03 CM

Reg. No. 2003 41265

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| NEWTON | | KOENIG | DECEMBER 17, 2003 | 10:20 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 5482 HARPERS FARM ROAD #B-2 | COLUMBIA | HOWARD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| ~~055-09-3963~~ 055-09-3963 | 1 ☐ M 2 ☐ F X | 88 Yrs. | | | AUG 3, 1915 | NEW YORK |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | HOWARD | COLUMBIA | 1 ☐ Yes X 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5482 HARPERS FARM RD., APT. B-2 | 21044 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☐ X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☐ X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | MANAGER | INSURANCE CO. |

| 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|---|
| JOSEPH | HARRY | KOENIG | FAYE | LICHTBLAU |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| BELLA KOENIG (WIFE) | 5482 HARPERS FARM RD., B-2 COLUMBIA, MD 21044 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | COLUMBIA MEMORIAL PARK | 12/19/03 | COLUMBIA, MD |

21. Signature of Funeral Service Licensee: Edward C Reed

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Congestive Heart Failure | Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b. | Advanced Arteriosclerosis | Years |
| Due to (or as a consequence of): c. | Renal failure | Years |
| Due to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☑ No | 1 ☐ Yes 2 ☐ No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| HAOKEN MD | D31172 | December 17, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HAOKEN MD 10700 CHARTER DR 200 COLUMBIA, MD 21044

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41266

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARIE ELIZABETH LIMMER
2. Date of Death: Month 12 Day 19 Year 03
3. Time of Death: 5:00 A M
4a. Facility Name (If not institution, give street and number): STELLA MARIS
4b. City, Town, or Location of Death: TIMONIUM
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 216.44.0199
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 2, 1945
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7710 WILSON AVENUE
10f. Zip Code: 21237
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 YRS
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BENEFIT AUTHORIZOR
16b. Kind of Business/Industry: SOCIAL SECURITY

17. Father's Name (First, Middle, Last): GEORGE A. LIMMER
18. Mother's Name (First, Middle, Maiden Surname): MARY ANNA SPANGLER

19a. Informant's Name/Relationship (Type, Print): MARY ANN HAND / COUSIN
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208: 4703 PARKVILLE CT., BALTIMORE, MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKWOOD CEMETERY
Date: DEC. 22, 2003
20c. Location - City or Town, State: PARKVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Kimberly A. Zemlock
22. Name and Address of Facility: EVANS FUNERAL CHAPEL 8500 HARFORD RD, PARKVILLE MD 21234

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ischemic Cardiomyopathy — Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
End Stage Renal Failure

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Bonnie Cohen MD
29c. License number: 041797
29d. Date signed (Month, Day, Year): 12/19/03
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bonnie Cohen 2300 Dulaney Valley Rd Timonium MD

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DECEMBER 19, 2003 5:00 A.M.

LIMMER, MARIE

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2003 41267

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Murrel W. Lewis, Sr. | 12/20/03 | 7:55am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 4 West 5th Avenue | Brooklyn Park | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-10-8259 | X 1 M 2 F | 84 Yrs. | | | 5/24/1919 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Brooklyn Park | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4 West 5th Avenue | 21225 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 X Widowed 4 Divorced | X Yes 2 No If Yes, Give Year or Dates: Navy WWII | 1 Yes X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | 0 | Truck Driver | Transportation |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Thomas A. Lewis | Sarah I. Reeves |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ina Pippin / Daughter | 4 West 5th Avenue, Brooklyn Park MD 21225 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Western Cemetery | 12/23/2003 | Baltimore MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Victor P. Doda, Jr. | Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA — 6 WKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE LUNG DISEASE - 60 YRS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ✓ Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 ✓ No | 1 Yes 2 ✓ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 Yes 2 ✓ No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ✓ Residence 6 Other (Specify) |

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 Yes 2 No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1 ✓ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Afroze Muneer MD | D45105 | 12/22/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AFROZE MUNEER
901 E. FORT AVE BALTIMORE MD 21230

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
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**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41268

LEX MARLIN

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): Marlin G. Lex

2. Dete of Deeth: Month December Day 15 Year 2003

3. Time of Death: 10:06 PM

4a Fecility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Deeth: Anne Arundel

**Funeral Director**

5. Social Security Number: 174-20-8121

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): May 15, 1928

9. Birthplace (State or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 313 Hospital Drive

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Maritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Worker

16b. Kind of Business/Industry: Confection

17. Father's Name (First, Middle, Last): Frank X. Lex

18. Mother's Name (First, Middle, Maiden Surname): Pheobe Manbeck

19a. Informant's Name/Relationship (Type, Print): Barbara A. Lex Ferguson (Dtr)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2296 Canteen Circle, Odenton, MD 21113

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hummelstown Cemetery

Date: 12/20 2003

20c. Location - City or Town, State: Hummelstown, PA

21. Signature of Funeral Service Licensee: Brian J. Graham

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Septicemia, Acute resp. distress — 2 WKS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:

b. Stage IV left hip wound, UTI

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Intracerebral hemorrhage, old CVA, h/o TIA, Anemia, malnutrition & dehydration

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [ ] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Rita Khandelwal, M.D. Attending Physician

29c. License number: D 29873

29d. Date signed (Month, Day, Year): 12/17/03

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): RITA KHANDELWAL MD, 1600 S. CRAIN HWY, #201 GLEN BURNIE, Md. 21061

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrer's Signature

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Donald Lennox
03-07110
AKG

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM 23a,27&28a-f PER ME G826 12/23/03 JH

# Certificate of Death

Reg. No. 2003 41269

2842

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Donald Lennox | November 7, 2003 | 10:05 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| John Hopkins Bayview Hospital | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| unk | 1☒M 2☐F | 60 Yrs. | | | June 23, 1943 | unk |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| DC | | Washington | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3018 Porter Street | 20008 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| unk<br>1☐Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☐No unk<br>If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | unk | unk |
| unk | unk | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| unk | unk |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| O.C.M.E. | 111 Penn Street Baltimore, MD 21201 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC and COCAINE INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? ☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

| 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| found 11/07/03 | unknown M | 1☐Yes 2☒No | UNKNOWN |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): MOTEL

28f. Location (Street and Number or Rural Route Number, City or Town, State): 6510 FRANKFORD AVE. BALTIMORE,MD.

29a. Certifier (Check only one) 1☐Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☒Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Wayne McKeel MD | O.C.M.E. | November 8, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARYANN A. KOREL 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41270

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Pamela Lowery
2. Date of Death (Month, Day, Year): December 4, 2003
3. Time of Death: 3 Pm
4a. Facility Name (If not institution, give street and number): St. Joseph's Hospital
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-89-2189
6. Sex: 1☐ M 2☒ F
7. Age (If yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 19, 1953
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 420 E. horraine Ave
10f. Zip Code: 21218
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Aviation Parts

17. Father's Neme (First, Middle, Last): Harold Calhoun
18. Mother's Name (First, Middle, Maiden Surname): Mildred Kee

19a. Informant's Name/Relationship (Type, Print): Anthony A. howery (Husb)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 420 E. horraine Ave Balto, Md. 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. Zion Cemetery
Date: 12/10/03
20c. Location - City or Town, State: Lansdowne Md.

21. Signature of Funeral Service Licensee: Ronald A Grayson
22. Name and Address of Facility: Ronald A. Grayson F.H. P.A. 108 W. North Ave Balto, Md. 21201

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):
b. HYPERTENSIVE HEART DISEASE — YEARS

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
END STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Jane S. Abrams MD
29c. License number: D047051
29d. Date signed (Month, Day, Year): 12/19/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 200 EAST 33rd ST # 523, BALTIMORE MD. 21218

**State Registrar**

31. Date filed (Month, Day, Year): DEC 20 2003
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #20b-c per fh #30 12/22/03 tas — Certificate of Death — Reg. No. 2003 41271

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Asia | | Monroe | 12 / 18 / 2003 | 2:45p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 20 Lambourne Rd. Apt. T. 4 | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-33-6172 | 1☐M 2☒F | 1 Yrs. | 8 / 18 | | 4-29-02 | Japan |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Baltimore | Towson | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 20 Lambourne Rd. Apt T 4 | 21204 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| Child | | Child | NA |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Corey James Monroe | Malinda McNeil |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Corey & Malinda Monroe Parents | 20 Lambourne Rd. Apt. T4, Towson, Md. 21204 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory, or other place) / Date | 20c. Location - City or Town, State |
|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Brigadier Gen. Wm. Ewing Cem. C. Doyle 12-22-03 Vet. Cem. 12-24-03 | ~~Ewing, N.J.~~ Arneytown, NJ |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ D Lady Warner | March F.H. East 1101 E. North Ave. Baltimore, Md. 21202 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute myeloid leukemia — 9/2002-12/03

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Sepsis — 1day
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ A McKee MD, physician | D60383 | 12/19/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Amy E. McKee Johns Hopkins Hospital Balto., MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ Theresa A. Smith |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#30 9/ 1

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41272

Patient known as Brenda Miles

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Brenda E. Miles

2. Date of Death Month: December Day: 16 Year: 2003

3. Time of Death: 06 12 AM

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

**Funeral Director**

5. Social Security Number: 215-46-8193

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02 28 47

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Hampstead

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3905 Shilah Ave

10f. Zip Code: 21074

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+): 2yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant Manager

16b. Kind of Business/Industry: Picture People

17. Father's Name (First, Middle, Last): Robert L. Franklin Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mozella E. Botts

19a. Informant's Name/Relationship (Type, Print): Kenyada Williams-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10020 Hillgreen Circle Apt B, Cockeysville MD 21030

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park

Date: 12/20/03

20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Dale March

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Intracranial Hemorrhage — 3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Arterial Hypertension — 10 years
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P Crimi M.D.

29c. License number: RES - 000

29d. Date signed (Month, Day, Year): 12, 16, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paolo F. Crimi MD, Sinai Hospital of Baltimore

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No 2003 41273

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| JEREMY DAVID MCHENRY JR | DEC | 04 | 2003 | 1924 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| NATIONAL NAVAL MEDICAL CENTER | BETHESDA | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| none | 1 X M 2 ☐ F | Yrs. | | 9 | | | Nov 25, 2003 | Bethesda, MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Severn | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8273 Severn Orchard Circle | 21144 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| none | | none | none |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jeremy David McHenry | Heather Renee Freeman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Heather R. Freeman - Mother | 8273 Severn Orchard Circle Severn, MD 21144 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | United Meth. Ch. Cem. | 12/9/2003 | Cheswold, Delaware |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Dennis Dettmer | Faries Funeral Home Dover, DE 19904 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | NECROTIZING ENTEROCOLITIS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a consequence of): | |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | MD11354 (HI) | 12 05 2003 |

| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | |
|---|---|
| AGNES SIEROCKA MAJ MC USA | NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20889-5600 |

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41274

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John H. Meyer
2. Date of Death (Month, Day, Year): December 14, 2003
3. Time of Death: 7:49A M
4a. Facility Name (If not institution, give street and number): Casey House Hospice
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 060-05-1295
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 95 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): Aug. 10, 1908
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1336 Hornell Drive
10f. Zip Code: 20905
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Route Salesman
16b. Kind of Business/Industry: Food Service

17. Father's Name (First, Middle, Last): Heinrich Meyer
18. Mother's Name (First, Middle, Maiden Surname): Meta (Unknown)

19a. Informant's Name/Relationship (Type, Print): John Meyer / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1336 Hornell Dr., Silver Spring, MD 20905

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Whiting Memorial Park
Date: Dec.19, 03
20c. Location - City or Town, State: Whiting, NJ

21. Signature of Funeral Service Licensee: Nancy J. Bessette #CE 0324
22. Name and Address of Facility: Manchester Memorial Home 28 School House Road Whiting, NJ 08759

**Physician /Medical Examiner**

23a. Part I. Enter the disease, injury, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — 2 Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Coronary Artery Disease — Years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure
Deep Vein Thrombosis
Aortic Stenosis

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: E. P. Libre
29c. License number: DO 9470
29d. Date signed (Month, Day, Year): December 14, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene P. Libre, MD, 10400 Connecticut Ave., Kensington, MD 20895

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41275

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Mary Shaw Mills
2. Date of Death (Month, Day, Year): December 18, 2003
3. Time of Death: 11:00 AM
4a. Facility Name *(If not institution, give street and number)*: Riverview Nursing Home
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 214-38-3122
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 11, 1911
9. Birthplace *(State or Foreign Country)*: Indiana

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1900 Monumental Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 4 Years
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Teacher
16b. Kind of Business/Industry: Baltimore County Board of Education

17. Father's Name *(First, Middle, Last)*: John Shaw
18. Mother's Name *(First, Middle, Maiden Surname)*: Mabel James

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Bruce A. Mills (Son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1907 Adams Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Moreland Mem. Park Cem.
Date: 12/22/2003
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrhythmias — 2-3 hrs

Due to (or as a consequence of):
b. Probable Recurrent Myocardial Infarction — 4-5 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Coronary Artery Disease — un-known

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
End Stage Renal Disease, COPD, Pulmonary Embolism, Hypothyroidism

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D-38754
29d. Date signed *(Month, Day, Year)*: 12-18-2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MALIKA WASSEM. 709 EASTERN BLVD. MD-21221

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 22 2003
32. Registrar's Signature: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physicien:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41276

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Edward Millikin

2. Date of Death: Month December Day 20 Year 2003

3. Time of Death: 8:45 A M

4a. Facility Name (If not institution, give street and number): 6113 Regent Park Road

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-18-0668

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): May 12, 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6113 Regent Park Road

10f. Zip Code: 21228

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic

16b. Kind of Business/Industry: Reeds Air Conditioning and Refrigeration

17. Father's Name (First, Middle, Last): Robert Millikin

18. Mother's Name (First, Middle, Maiden Surname): Carmilla Bromwell

19a. Informant's Name/Relationship (Type, Print): Mildred Millikin - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6113 Regent Park Road Catonsville, Maryland 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park

Date: 12/23/03

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: M. Pfh

22. Name and Address of Facility: Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pulmonary Fibrosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T. Kawaja MD

29c. License number: D25112

29d. Date signed (Month, Day, Year): 12/22/2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TAHOORA KAWAJA 20 Crossroads Dr Suite 101 Owings Mills MD 21117

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Medical Certification: To be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41277

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Tillisa F. Martin | December 18 2003 | 12 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Mariner Health | Glen Burnie | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-09-2310 | 1☐ M 2☒ F | 89 Yrs. | | | Jan. 29, 1914 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2809 Delaware Avenue | 21227 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jeremiah Fowler | Annie E. |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Margaret Davis - Cousin | 2809 Delaware Avenue Baltimore, Maryland 21227 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Meadowridge Mem. Park | 12/20/03 | Elkridge, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ M. Pdn | Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. URINARY TRACT INFECTION

Due to (or as a consequence of):

c. ALZHEIMER'S DEMENTIA

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown | 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? 1☐ Yes 2☒ No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No |
|---|---|

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? 1☐ Yes 2☒ No | 26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D51596 | December 19th 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K Amberlavenue 716 Maidenchoice Lane 111 Catonsville MD 21228

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41278

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Chikako | | McMichael | 12 | 16 | 2003 | 4:30A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Harford Memorial Hospital | Havre de Grace | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-26-5080 | 1☐ M 2☒ F | 78 Yrs. | | | 07/03/1925 | Japan |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Havre de Grace | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 703 Gashey Drive | 21078 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Asian |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 4 years | Registered Nurse | Nursing Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Unknown | Unknown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joseph McMichael- Son | 703 Gashey Dr., Havre de Grace, MD 21078 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Mt. Erin Cemetery | 12/18/03 | Havre de Grace, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Sylaine M. Smith | Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary arrest

Due to (or as a consequence of):
b. Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Pneumonia

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Colon cancer

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Lee M.D | D0058904 | 12/16/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ha J. Lee 319 S. Union Avenue Havre de Grace MD 21078

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | Sylaine M. Smith |

DHMH 17 Rev 1/2001

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

McMichael, Chikako

4

20

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41279

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| John J. Misinger | December 19, 2003 | 930 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Maryland General Hospital | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-56-5839 | 1 X M 2 F | 51 Yrs. | | | MAY 10, 1952 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3666 Falls Road | 21211 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Laborer | Plastics |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Glen Misinger | Margaret Gannon |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary F. Misinger/Wife | 3666 Falls Road Baltimore, MD 21211 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Metro Crematory Inc. | 12-22-03 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Dawn F. McDonald | Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Severe Anoxic encephalopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myotonic dystrophy

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death Check on one

Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 Yes 2 No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Ayman Saad, MD | 89477 | 12/19/03 |

31. Name and address of person who completed cause of death (Item 29a) (Type or Print) Ayman Saad M.D. c/o Maryland General Hospital

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

JOHN MISINGER

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41280

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: CHESTER ANTHONY MARCHEL
2. Date of Death Month: 12 Day: 16 Year: 2003
3. Time of Death: 1:45 PM
4a. Facility Name *(If not institution, give street and number)*: BALTIMORE VA MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-16-0952
6. Sex: XX M 2☐ F
7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG 27, 1924
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: XX Yes 2☐ No
10e. Street and Number: 1112 SOUTH PACA STREET
10f. Zip Code: 21230
10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1☐ Never Married 2☐ Married 3XX Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No — If Yes, Give Year or Dates: 1943-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2XX No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CARPENTER
16b. Kind of Business/Industry: BUILDING

17. Father's Name *(First, Middle, Last)*: JULIUS MARCHEL
18. Mother's Name *(First, Middle, Maiden Surname)*: STELLA ZRZACEKA

19a. Informant's Name/Relationship *(Type, Print)*: JOSEPHINE T. SCARDINA (FRIEND)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1112 SOUTH PACA STREET; BALTIMORE, MARYLAND 21230

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LOUDON PARK CEMETERY
Date: DEC. 20, 2003
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Dana J. Schuster
22. Name and Address of Facility: LOUDON PARK FUNERAL HOME, 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pulmonary embolism
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Transitional Cell carcinoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Schroeder, MD
29c. License number: P15905
29d. Date signed *(Month, Day, Year)*: 12/16/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard M. Schroeder 10N Greene Street Balto MD 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 22 2003
32. Registrar's Signature: [illegible]

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

2+1

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41281

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Hattie McKoy
2. Date of Death Month Day Year: 12 - 16 - 03
3. Time of Death: 848 AM
4a. Facility Name (If not institution, give street and number): Bayview John Hospital
4b. City, Town, or Location of Death: Balto.
4c. County of Death:

**Funeral Director**

5. Social Security Number: 242-62-1889
6. Sex: 1☐M 2☑F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-16-41
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Md
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 1110 McLeer Ct
10f. Zip Code: 21202
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☑Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Clothing

17. Father's Name (First, Middle, Last): Booker T. McLean
18. Mother's Name (First, Middle, Maiden Surname): Thelma Cowan

19a. Informant's Name/Relationship (Type, Print): Mary McKoy Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4013 Eierman Balto. Md. 21206

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: 12/20/03
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Miller's Metropolitan Chapel 1638 N. Broadway Balto. MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ISCHEMIC CARDIOMYOPATHY — 4 YEARS

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE — 4 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 4 YEARS

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC RENAL FAILURE, CONGESTIVE HEART FAILURE, ISCHEMIC COLITIS, HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA
26. Place of Death (Check only one) Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nathan A Scott III, M.D.
29c. License number: D34484
29d. Date signed (Month, Day, Year): 12-18-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NATHAN A. SCOTT III, M.D. 1000 E. EAGER ST. BALTIMORE, MARYLAND 21202

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

03-07564
TENIA MANIGO
WHM

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Unpend Item #23a&b,27 per me G828 2/5/04 tas
Amend Item 5 per FH,G828,02/13/04 tas

# Certificate of Death

Reg. No. 2003 41282

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| TENIA | L. | MANIGO | NOVEMBER 27, 2003 | 4:50 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-48-6200 | 1☐M 2☑F | 22 Yrs. | | | 10-29-81 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md | | Baltimore | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2318 E. Fairmount | 21224 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☑Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Student | Education |
| | 2 | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Darrell Manigo | Shiela Cook |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Shiela Manigo Mother | 814 Dumbarton Ave Balto. Md. 21218 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Garden of Faith | 12-3-03 | Raspeburg, Md. |

21. Signature of Funeral Service Licensee: ▶ Geoffrey Miller

22. Name and Address of Facility: Miller's Metropolitan Chapel 1639 N. Broadway Balto, Md.

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, injury, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Probable early sepsis | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Acute endometritis complicating first trimester pregnancy | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☒Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☒Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Tasha L Zemmus MD | OCME | NOVEMBER 28, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tasha L Zemmus M.D 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2843

#5 23d

Leroy Macklin
03-7841
AKG

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar **Unpended Item#23a,27,Per ME,G828,2/17/04ep**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41283

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Leroy Macklin | December 6, 2003 | 5:00 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| House of Corrections Annex | Jessup | Anne Arundel |

**Funeral Director**

2844

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| unk | 1☒ M 2☐ F | 58 Yrs. | | | July 20, 1945 | unk |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Jessup | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| P. O. Box 534 | 20794 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| unk<br>1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☐ No unk<br>If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | unk | unk |
| unk | unk | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| unk | unk |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| O.C.M.E. | 111 Penn Street Baltimore, MD 21201 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. **Hypertensive Atherosclerotic Cardiovascular Disease** | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☐ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) At scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Theodore M. King | O.C.M.E. | December 7, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JIMMY MCQUEEN
Unk 03-336
03-07144
RPD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41284

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Jimmy McQueen | November 9, 2003 | 1230 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University Hospital | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| unk | 1 X M 2 ☐ F | 47 Yrs. | | | Oct 28, 1956 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1506 Traction Street | 21217 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | unk | unk |
| 11 | 0 | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Luther McQueen | Sandy mae Eden |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Denise McQueen/sister | 503 N. Robinson Street Baltimore, MD 21205 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. multpk stab and cutting wounds | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 ☐ No | 1 X Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 X Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 11-8-03 | 11:43 PM | 1 ☐ Yes 2 X No | Subject cut and Stabbed |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| street | Vat Block West Baltimore Street Baltimore MD |

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Patricia Aronica-Pollak MD | O.C.M.E. | November 9, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICIA ARONICA-POLLAK MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41285

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LOUISE MILDRED MILLS
2. Date of Death (Month, Day, Year): DECEMBER 18, 2003
3. Time of Death: 9:35 AM
4a. Facility Name (If not institution, give street and number): Joseph Richie House, Hospice
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: 265-07-1516
6. Sex: 1☐M 2☑F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 8, 1914
9. Birthplace (State or Foreign Country): FLORIDA

Usual Residence of Decedent

10a. State: MD. | 10b. County: ANNE ARUNDEL | 10c. City, Town or Location: PASADENA | 10d. Inside City Limits: 1☐Yes 2☑No

10e. Street and Number: 8639 HOULTON HARBOUR | 10f. Zip Code: 21122 | 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☑Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SHORT ORDER COOK
16b. Kind of Business/Industry: RESTAURANT

17. Father's Name (First, Middle, Last): MONTGOMERY MARTIN
18. Mother's Name (First, Middle, Maiden Surname): MILDRED DOUGHERTY

19a. Informant's Name/Relationship (Type, Print): CHARLES W. MILLS, SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8639 HOULTON HARBOUR PASADENA, MD. 21122

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GATES OF HEAVEN CEMETERY | Date: 12-23-03
20c. Location - City or Town, State: SILVER SPRING, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatic Failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Gastric Carcinoma with hepatic and pancreatic metastases | 19 months
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery (Month, Day, Year)

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) INPATIENT HOSPICE

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D41476
29d. Date signed (Month, Day, Year): 12.18.2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND W. WILSON M.D. ; 6565 N. CHARLES ST, #916, BALTIMORE, MD. 21204

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41286

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| TOBY NEEDEL | DECEMBER 17, 2003 | 1:20 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| NORTHWEST HOSPITAL | RANDALLSTOWN | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-28-1177 | 1☐ M 2☒ F | 71 Yrs. | | | MAR. 25, 1932 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7 SLADE AVENUE #204 | 21208 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | HOUSEWIFE | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| SAMUEL MILLER | NAOMI LIEBOWITZ |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| STUART NEEDEL / SON | 9829 N.W. 2ND STREET - PLANTATION, FL 33324 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | FORBAND CEMETERY | 12/19/2003 | ROSEDALE, MD |

21. Signature of Funeral Service Licensee ▶ Scott M. Cottle

22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Michael Rothkin, MD | D43481 | DECEMBER 17, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL ROTHKIN 5401 OLD COURT ROAD RANDALLSTOWN MARYLAND 21133

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## *Certificate of Death*

Reg. No. 2003 41287

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Elizabeth Ohanian
2. Date of Death Month / Dey / Year: December 18 2003
3. Time of Death: 350 pm
4a. Facility Name *(If not institution, give street and number)*: Copper Ridge
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 092-26-0256
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: Oct 24 1924
9. Birthplace *(State or Foreign Country)*: France

Usual Residence of Decedent

10a. State: Md
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 710 Obrecht Road
10f. Zip Code: 21784
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: clothing salesperson
16b. Kind of Business/Industry: retail sales

17. Father's Neme *(First, Middle, Lest)*: Der Krikorian
18. Mother's Name *(First, Middle, Maiden Surname)*: Hagopian

19a. Informent's Name/Relationship *(Type, Print)*: Christopher Ohanian (son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 5040 Netherstone Ct. Columbia, MD 21045

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Springfield Cemetery
Date: 12-23-03
20c. Location - City or Town, State: Sykesville, Md

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert
22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md 21784

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End stage dementia — years

Due to (or as a consequence of):
b. cerebrovascular accident — weeks

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Vascular dementia — years

Due to (or as a consequence of):
d. ASCVD — years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Sepsis, osteoporosis, anemia, hypothyroid depression, gait disturbance

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D 68758
29d. Date signed *(Month, Day, Yeer)*: December 19, 2003

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Alvin S. Baker MD 710 Obrecht Road Sykesville, MD 21784

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 22 2003
32. Registrar's Signature: ▶ [signature]

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41288

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Claire Parenteau
2. Date of Death Month 12 Day 18 Year 2003
3. Time of Death 5:A M
4a. Facility Name (If not institution, give street and number): 4307 Arizona Ave.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 039-24-6960
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-17-39
9. Birthplace (State or Foreign Country): R.I.

Usual Residence of Decedent

10a. State: Md.
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3725 Ellerslie Ave
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grades
College (1-4or 5+): 4 + yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NUN
16b. Kind of Business/Industry: Baltimore Franciscan Sisters of

17. Father's Name (First, Middle, Last): Arthur Parenteau
18. Mother's Name (First, Middle, Maiden Surname): Claire McNiff

19a. Informant's Name/Relationship (Type, Print): Sister Linda Tan Employer
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3321 South Lake Dr., St. Francis, WI 53235-3799

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Elizabeth Convent
Date: 12-23-03
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ Lladys Wane
22. Name and Address of Facility: March F.H. East Baltimore, Md. 21202 1101 E. North Ave.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Breast Cancer — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death: 5 years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Charles A. Padgett MD
29c. License number: D15546
29d. Date signed (Month, Day, Year): Dec 18, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles A Padgett MD, 5601 Loch Raven Blvd, Baltimore, MD

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2003 41289

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret V. Parker

2. Date of Death (Month, Day, Year): December 14 2003

3. Time of Death: 4:06a M

4a. Facility Name (If not institution, give street and number): Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 212-20-2431

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02 28 25

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX 1☐ Yes 2☐ No

10e. Street and Number: 4103 Ridgewood Ave

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4XX Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6th grade

College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Lloyd Kay Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary Dorsey

19a. Informant's Name/Relationship (Type, Print): Virginia Jones-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4300 Ridgewood Ave, Baltimore Md 21215

20a. Method of Disposition: XX 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park

Date: 12/19/03

20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Cynthia Marie Mallo

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary embolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. new onset of bronchitis

Due to (or as a consequence of):

d.

IF FEMALE: NA

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☑ OA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sofia M. Surick, M.D.

29c. License number: D002567

29d. Date signed (Month, Day, Year): 12/19/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SOFIA M. SURICK M.D. 522 DOLPHIN ST. BALTIMORE MD 21217

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41290

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Harold G. Phillips
2. Date of Death (Month, Day, Year): December 18 2003
3. Time of Death: 8:00 AM
4a. Facility Name (If not institution, give street and number): 117 Appian Way
4b. City, Town, or Location of Death: Pasadena
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 232-24-3181
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 07 1920
9. Birthplace (State or Foreign Country): WV

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7828 East Shore Road
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Automobiles

17. Father's Name (First, Middle, Last): Oakey E. Phillips
18. Mother's Name (First, Middle, Maiden Surname): Grace Stevens

19a. Informant's Name/Relationship (Type, Print): Alberta Phillips (spouse)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7828 East Shore Drive, Pasadena, MD 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Pifer Cemetery
Date: Dec. 23 2003
20c. Location - City or Town, State: St. George, WV

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease — Approximate Interval Between Onset and Death: 20 Yrs.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Ischemic Cardiomyopathy — 10 Yrs.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Osteoporosis, Multiinfarct Dementia

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) granddaughter

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): [X] 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Attending Physician
29c. License number: D44973
29d. Date signed (Month, Day, Year): December 18, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gurpreet S. Sawhney, M.D. 325 Hospital Dr., #202, Glen Burnie, MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41291

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Virginia Rebecca Pope | December 16, 2003 | 5:30 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University Specialty Home & Hospital | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-12-3843 | 1☐M 2☒F | 83 Yrs. | | | May 21, 1920 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | | Parkton | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 207 Bentley Road | 21120 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 Years | | Crossing Guard | Balto. County Gov't |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Bowen | Clester Snyder |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Henry C. Sauer, Jr./friend | 1007 Cedar Creek Road Essex, Maryland 21221 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Hilltop Service Corp. | 12/18/2003 | Towson, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Dan C. Duda | Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute renal failure | 1 Month |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Cerebrovascular accident | 1 month |
| | c. Due to (or as a consequence of): Hypertension | yrs |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☑**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ CMehta MD | D34974 | Dec. 17th 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHAPU MEHTA, MD 601, South Charles Street, Baltimore, MD 21230

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41292

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Robert Alfred Peloquin | December 16, 2003 | 5:39A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Fort Washington Hospital | Fort Washington | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 001-24-6216 | XX 1 M 2 F | 70 Yrs. | | | 09/10/1933 | Massachusetts |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George's | Fort Washington | 1 Yes XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12101 Ballina Court | 20744 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married XX 2 Married 3 Widowed 4 Divorced | XX Yes 2 No If Yes, Give Year or Dates: Retired 1993 | 1 Yes 2 XX No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5 + | Oceanographer | Federal Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph Ulderic Peloquin | Gilberta Desrochers |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia M. Peloquin / Wife | 12101 Ballina Court Ft. Washington, MD. 20744 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Arlington Nat'l. Cem. | 12/30/2003 | Arlington, Virginia |

21. Signature of Funeral Service Licensee: Geo. P. Kalas Jr.

22. Name and Address of Facility: Geo. P. Kalas Funeral Home, 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Respiratory Failure | 6 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Amyotrophic Lateral Sclerosis | 6 years |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 XX No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 XX ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Chaudhry | D34831 | December 16, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vinay Chaudhry, M.D. 601 N. Caroline St.#5072 Baltimore,MD.21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41293

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Evelyn K, Preston

2. Date of Death: Month Dec. Day 17 Year 2003

3. Time of Death: 4:35 P M

4a. Facility Name (If not institution, give street and number): Edenwald Retirement Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 214-36-7289

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 23, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 800 Southerly Road #204

10f. Zip Code: 21286

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): housewife

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): William Kirsch

18. Mother's Name (First, Middle, Maiden Surname): Laura Cunningham

19a. Informant's Name/Relationship (Type, Print): Kenneth Hutcherson/brother in law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Croftley Road Lutherville, MD 21093

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. aspiration pneumonia — 1hr

Due to (or as a consequence of):

b. Diverticular bleeding — 1wk

Due to (or as a consequence of):

c. Alzheimer's Dementia — 5 yrs.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] physician

29c. License number: D29769

29d. Date signed (Month, Day, Year): 12/17/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marcelino D. Aguoane MD 516 N. Rolling Rd Balto Md 21228

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

EVELYN K. PRESTON

DHMH 17 Rev 1/2001

ORIGINAL

SHawn Phillips
UNK 03-337
03-7912
AKG

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2003 41294

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Shawn L. Phillips
2. Date of Death (Month, Day, Year): December 9, 2003
3. Time of Death: 13:26 PM
4a. Facility Name (If not institution, give street and number): University Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

**Funeral Director**

5. Social Security Number: 212-11-4514
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 21 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-26-82
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 218 E Chase Street 3rd FL
10f. Zip Code: 21202
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security
16b. Kind of Business/Industry: Protection

17. Father's Name (First, Middle, Last): Percell Phillips
18. Mother's Name (First, Middle, Maiden Surname): Shirley Milteer

19a. Informant's Name/Relationship (Type, Print): Shirley Phillips mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5525 Cadillac Baltimore MD

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Zion Cemetery
Date: 12/17/03
20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Miller's Metropolitan Chapel 1639 N. Broadway Balto MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death:

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year): FOUND 12/9/03
28b. Time of Injury: FOUND 1130 AM
28c. Injury at Work? 1 ☐ Yes 2 ☑ No
28d. Describe how injury occurred: SUBJECT JUMPED FROM BUILDING
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET BENEATH BUILDING
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1100 BLOCK GUILFORD ST, BALTIMORE, MD

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 10, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For Stete Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41295

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Jajeanne M. Priest | Dec 16 2003 | 11:22 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Genesis ElderCare - The Pines | Easton | Talbot |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 217-03-0178 | 1☐M 2☒F | 85 Yrs. | | | | | July 19, 1918 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Talbot | St. Michael's | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 24700 Deep Water Point Drive | 21663 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | secretary | unk |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Henry Litz | Anna Harker |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| William Priest/spouse | 24700 Deep Water Point Drive St. Michael's Md 21663 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☒Donation 5☐Other (Specify) | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Leukemia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Myelodysplasia | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☑No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| DO | #41818 | 12-16-2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Patrick Sterling 505 Idlewild Ave Easton MD 2164

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

JaJeanne Priest
**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41296

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JAMES OLIVER Phillips JR.
2. Date of Death: Month December Day 20 Year 2003
3. Time of Death: 7:05A. M.
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 215-14-6716
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUL. 22, 1922
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 ☐ Yes 2 ☑ No
10e. Street and Number: 908 PHYLEN COURT
10f. Zip Code: 21061
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 9-43/11-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EXTERMINATOR
16b. Kind of Business/Industry: PESTICIDES

17. Father's Name (First, Middle, Last): JAMES OLIVER Phillips
18. Mother's Name (First, Middle, Maiden Surname): MABLE GRISINGER

19a. Informant's Name/Relationship (Type, Print): NINA MITCHELL DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1003 LANGLEY RD. GLEN BURNIE, MD. 21060

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BAYVIEW CREMATORY
Date: 12-22-03
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: L. M. Daugherty
22. Name and Address of Facility: Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road • Pasadena, MD. 21122

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Pancreatic cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD.
29c. License number: D43977
29d. Date signed (Month, Day, Year): December 20 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cyprian Ejiofor 301 Hospital Dr. Glen Burnie, MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41297

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Rosie E. Pitts

2. Date of Death (Month, Day, Year): DEC. 17, 2003

3. Time of Death: 9:25PM

4a. Facility Name (If not institution, give street and number): 46 S. Catherine St.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 216-24-0010

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/29/1927

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 46 S. Catherine Street

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Assistant

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Rodny Smith

18. Mother's Name (First, Middle, Maiden Surname): Louise Butler

19a. Informant's Name/Relationship (Type, Print): Kenneth Pitts / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 306 Shagbark Rd., Baltimore, Maryland 21220

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Ceme.

Date: 12/23/2003

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: The Derrick C. Jones F/H, P.A. 4611 Park Heights Ave., Baltimore, Maryland 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — 30 MIN.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ARTERIOSCLEROTIC HEART DISEASE — UNKNOWN

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE VASCULAR DISEASE
DIABETES MELLITUS, TYPE 2
HYPERLIPIDEMIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D.W. Stewart, M.D. (attending physician)

29c. License number: D10790

29d. Date signed (Month, Day, Year): DEC. 19, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D.W. STEWART, M.D. 222 W. COLD SPRING LANE BALTIMORE, MD. 21210

**State Registrar**

31. Date filed (Month, Day, Year): DEC 20 2003

32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Items 9,19a per Inf.,G827,01/07/04dhb

# Certificate of Death

Reg. No. 2003 41298

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Michael A. Quintavalle
2. Date of Death: Month: December; Day: 15; Year: 2003
3. Time of Death: 6:00 AM
4a. Facility Name (If not institution, give street and number): Baltimore VA Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 112-18-7799
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 04 1928
9. Birthplace (State or Foreign Country): ~~NJ.~~ NY

Usual Residence of Decedent

10a. State: MD.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7943 St. Bridget Lane
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Food

17. Father's Name (First, Middle, Last): Pasquale Quintavalle
18. Mother's Name (First, Middle, Maiden Surname): Mary Gisonna

19a. Informant's Name/Relationship (Type, Print): Elizabeth Quintavalle ~~Elizabeth Quintavalle~~ wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7943 St. Bridget Lane, Dundalk, Md. 21222

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forrest VA. Cem
Date: December 23, 2003
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Anthony Connelly
22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | ACUTE RESPIRATORY FAILURE | 1 DAY |
| Due to (or as a consequence of): b. | INTRA ABDOMINAL SEPSIS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RHEUMATOID ARTHRITIS

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ahmet Kilic, MD
29c. License number: 20-10683
29d. Date signed (Month, Day, Year): December 15, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ahmet Kilic, M.D. 10 N. Greene St. Baltimore, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 20 2003
32. Registrar Signature

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Quintavalle, Michael

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41299

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| MARGARET LOUISE REED | 12 / 10 / 2003 | 4:00 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GOOD SAMARITAN HOSPITAL | BALTIMORE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-28-5205 | 1☐ M 2☒ F | 74 Yrs. | | | 6-12-29 | S.C. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | NA | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 149 N. Potomac St. | 21224 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11th grade | | Nurses Aid | North Charles Gen'l |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James D. Fowler | Cora McCant |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Willie J. Carter Nephew | 1317 Marion St., Harrisburg, Pa. 17102 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Mt. Carmel Cem. | 12-22-03 | Dundalk, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gladys Wayne | March F.H. East Baltimore, Md. 21202 1101 E. North Ave. |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. UTI

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☑ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPOGLYCEMIA

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☑ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ S. Thomas MD | D0060687 | 12/10/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SONY M THOMAS MD, GOOD SAMARITAN HOSPITAL

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ Steven K Smith |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

Item#17perFH

1- For State Registrar Amend Item#1perPHYG826 12/29/03 EW

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41300

**Physician or /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ~~David Collins Ruffin Jr.~~ ~~David Ruffin IV~~

2. Date of Death Month: December Day: 21 Year: 2003

3. Time of Death: 1:45 AM

4a. Facility Name (If not institution, give street and number): Northwest Hospital

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 170-03-2689

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 10, 1915

9. Birthplace (State or Foreign Country): Pennsylvania

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 3427 Carriage Hill Circle #101

10f. Zip Code: 21133

10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: U.S. Postal Service

17. Father's Name (First, Middle, Last): ~~David Collins Ruffin~~ David Collins Ruffin Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ella M. West

19a. Informant's Name/Relationship (Type, Print): David Collins Ruffin, III/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 501 12th Street NE #3 Washington DC 20002

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 12-22-03

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service License: Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

lung cancer

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alice Hsieh

29c. License number: H43974

29d. Date signed (Month, Day, Year): December 21, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alice Hsieh Northwest Hospital Randallstown, Maryland

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

3

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM31 PER PHY G826 12/22/03 JH **Certificate of Death** Reg. No. 2003 41301

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ~~MELVIN ROEDEL~~ MELVIN WILLIAM ROEDEL,SR.

2. Date of Death Month Day Year: DECEMBER 16, 2003

3. Time of Death: 1645 M

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 217-16-8581

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 28, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8800 Old Harford Road

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper

16b. Kind of Business/Industry: Contracting

17. Father's Name (First, Middle, Last): John W Roedel

18. Mother's Name (First, Middle, Maiden Surname): Emma Behrens

19a. Informant's Name/Relationship (Type, Print): James C. Anderson (Brother-in-law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Bennington Road, Convent Station, NJ 07960

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Cemetery

Date: 12/19/2003

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD, Atrial fibrillation

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D18230

29d. Date signed (Month, Day, Year): DECEMBER 16, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. SHASHIDHARAN, 9601 LOCH RAVEN BOULEVARD, MD 21239

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

ROBERT ROBERTSON
03-08004
RKD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM 23a,27&28a-f PER ME G827 1/08/04 JH

# Certificate of Death

Reg. No. 2003 41302

2845

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Robert | R | Robertson | DECEMBER 12, 2003 | 5:30P. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| UNION MEMORIAL HOSPITAL | BALTIMORE | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-38-6018 | 1 ☑ M 2 ☐ F | 59 Yrs. | | | 3-1-44 | North Carolina |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md | | Baltimore | 1 ☑ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1819 E. 32nd Street | 21218 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☑ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | X | Sanitation Tech | Sanitation |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JAme R. Robertson | Nancy Wilkerson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia Carter Sister | 1819 E 32nd Street Balto. MD 21218 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Bayview Crematory | 12/20/03 | Balto. MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Miller's Metropolitan Chapel 1639 N. Broadway Balto. Md. |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☒ Yes 2 ☐ No | 1 ☒ Yes 2 ☐ No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined

| 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| found 12-12-03 | found at 5:00p M | 1 ☐ Yes 2 ☒ No | UNKNOWN |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND AT RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State): 1819 E.32nd ST. BALTO,MD

29a. Certifier (Check only one)
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Ling Li. M.D | O.C.M.E. | DECEMBER 13,2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LING LI M.D 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

03-07535
IMGARD REIGER
WHM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#5,per FH,G835,9/22/04 TT

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #7,8,10g,20a-c,22 per fh G830 477/04 tas

# Certificate of Death

Reg. No. 2003 41303

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Imgard Reiger

2. Date of Death (Month, Day, Year): NOVEMBER 26, 2003

3. Time of Death: 1:08 PM

4a. Facility Name (If not institution, give street and number): 11501 CHARLTON DRIVE

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY CO

**Funeral Director**

5. Social Security Number: ~~unk~~ 215-54-6368

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): ~~80~~ 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~unk~~ May 19,1924

9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11501 Charlton Drive

10f. Zip Code: 20902

10g. Citizen of What Country? ~~unk~~ United States

11. Marital Status: unk
1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? unk
1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): O.C.M.E.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 Penn Street Baltimore, MD 21201

20a. Method of Disposition
1☐ Burial 2☒ Cremation 3☐ Removal from State
4☐ Donation ~~5☐~~ Other (Specify) ~~in state~~

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: 4-6-2004

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: Rapp Funeral And Cremation Services
~~State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201~~ 933 Gist Ave., Silver Spring, MD 20910

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Blunt force Injuries

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months?
1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy
1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy
4☐ Pregnant at time of death 5☐ Other (specify) _____
9☐ Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death
1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 11/26/03

28b. Time of Injury (Hours): 1:00 P M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: SUBJECT WAS BEATEN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 11501 Charlton Drive Silver Spring MD

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J.M. Titus

29c. License number: O C M E

29d. Date signed (Month, Day, Year): NOVEMBER 27, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41304

**Physician /Medical Examiner** | **Funeral Director**

1. Decedent's Name *(First, Middle, Last)*: Joan Smith
2. Date of Death Month Day Year: December 17 2003
3. Time of Death: 11:30 PM
4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore
5. Social Security Number: 220-36-7812
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 23 1938
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8509 Ramart DR.
10f. Zip Code: 21236
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12YRS | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker
16b. Kind of Business/Industry: home

17. Father's Neme *(First, Middle, Lest)*: Edwin Wheeler
18. Mother's Name *(First, Middle, Maiden Surname)*: Eva Gassman

19a. Informant's Name/Relationship *(Type, Print)*: Michelle Hoxter - daug.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8509 Ramart DR. Baltimore, MD 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☑ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Redeemer Ceme. | Date: Dec 20 2003
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service License: Loretta Wells
22. Name and Address of Facility: EVANS Chapel / Peaceful Alternatives 2325 York Rd Timonium MD 21093

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Bilateral Pneumonia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Refractory Anemia
Due to (or as a consequence of):
d. Pancytopenia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D54736
29d. Date signed *(Month, Day, Year)*: December 17, 2003
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr Kamlyn Auyeung 9000 Franklin Square Drive Baltimore Md 21237

**State Registrar**

31. Dete filed *(Month, Day, Year)*: DEC 22 2003
32. Registrar's Signature

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To the Hospital or Attending Physician:** The law requires thet tha death certificata be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as tha buriel-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Joan Smith

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41305

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| PRISCILLA | STRUCK | DECEMBER 15, 2003 | 2:10 A.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| MARINER HEALTH OF FOREST HILL | FOREST HILL | HARFORD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-24-3763 | 1☐M 2☒F | 76 Yrs. | | | 10-25-27 | FLORIDA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | Glen Arm | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11818 Harford Rd. | 21057 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White. |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Self Employed | Pizza Shop. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Otho V. Gray | Sarah E. Johnson. |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia A. Preisinger | 11818 Harford Rd. Glen Arm MD 21057. |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | BEL AIR, MD EVANS FUNERAL CHAPEL | 12-18-03 | FOREST HILL, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Kimberly A. Zaitotsky | 2325 YORK RD, TIMONIUM MD 21093. PEACEFUL ALTERNATIVES FUNERAL & CREMATION CR. |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of the left lung — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D0056607 | December 15th, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSEPH ANGELO #106, 602 South Atwood Rd. BEL AIR MD 21014

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41306

SS# 419-14-9722

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Eva Rachel Smith

2. Date of Death: Month 12 Day 13 Year 03

3. Time of Death: 11:30 Am

4a. Facility Name (If not institution, give street and number): 1419 Bayview Drive

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 419-14-9722

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/19/1915

9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1419 Bayview Drive

10f. Zip Code: 21078

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Jonathan Robert Watson

18. Mother's Name (First, Middle, Maiden Surname): Laura Frances Brown

19a. Informant's Name/Relationship (Type, Print): Jo-Ann Sale- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1419 Bayview Dr., Havre de Grace, MD 21078

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): R.A. Ferris & Co. Inc.

Date: 12/15/03

20c. Location - City or Town, State: West Chester, PA

21. Signature of Funeral Service Licensee: Melaine M. Smith

22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Physician /Medical Examiner**

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | 4 days |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Urinary Tract Infection

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bus 615, South Union Ave

29c. License number: D43115

29d. Date signed (Month, Day, Year): 12-15-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Havre de Grace, MD, 21078

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41307

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Vernon Spittel | 12.17.03 | 9 AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Millennium of Ellicott City | Ellicott City | Howard County |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217180411 | 1☒M 2☐F | 77 Yrs. | | | 1/12/1926 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Howard | Ellicott City | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8926 Town & Country Blvd. Apt. D | 21043 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 5/10/44 6/15/46 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | Mail Carrier | Post Master General |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Spittel | Charlotte Munch |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| David Spittel / son | 8926 Town & Country Blvd. Apt.D Ellicott City MD 21043 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | MD Vets Cemetery Crownsville | 12/22/2003 | Crownsville, Maryland |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Maryland 21227

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Adeno carcinoma | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

CVA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D50303 | 12/17/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
720-C Marden chase Lane Baltimore MD 21228

**State Registrar**

31. Date filed (Month, Day, Year) DEC 22 2003

32. Registrar's Signature [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41308

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CHARLOTTE NATALIE SPONHEIMER

2. Date of Death (Month, Day, Year): December 15, 2003

3. Time of Death: 1220p M

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 220-80-9921

6. Sex: 1☐ M XX F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEP. 7, 1921

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: XX 1 Yes 2☐ No

10e. Street and Number: 514 BRUNSWICK STREET

10f. Zip Code: 21223

10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

18b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): CHARLES HENRY LEINDECKER

18. Mother's Name (First, Middle, Maiden Surname): ERMA M. QUEEN

19a. Informant's Name/Relationship (Type, Print): GEORGE H. SPONHEIMER (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 514 BRUNSWICK STREET; BALTIMORE, MARYLAND 21223

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND VETERANS CEMETERY @ GARRISON FOREST

Date: DEC. 24, 2003

20c. Location - City or Town, State: OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee: John A. Schmaltz

22. Name and Address of Facility: LOUDON PARK FUNERAL HOME 3620 WILKENS AVENUE BALTIMORE, MARYLAND 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sora Hahn, MD

29c. License number: 89496

29d. Date signed (Month, Day, Year): 12/15/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sora Hahn, Maryland General Hospital

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Sponheimer, Charlotte

5

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2003 41309

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Tyrone Sanderlin-Bey
2. Date of Death: Month Dec, Day 14, Year 2003
3. Time of Death: 5:05PM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-70-1822
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Dec. 9, 1959
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 ☐ Yes 2 ☑ No
10e. Street and Number: 6208 Coporeway
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Ground Keeper
16b. Kind of Business/Industry: Ground Keeping

17. Father's Name (First, Middle, Last): Charles Muse
18. Mother's Name (First, Middle, Maiden Surname): Frances Sanderlin

19a. Informant's Name/Relationship (Type, Print): Nicole Sanderlin - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3167 Leeds St. Balto., MD 21229

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Mem. Park
Date: 12-19-03
20c. Location - City or Town, State: Randallstown, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gary P March F/H 2710 Fredhilton Pass Balto., MD 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | End-Stage renal disease | years |
| Due to (or as a consequence of): b. | Diabetes mellitus | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Paralysis of lower extremities after transverse myelitis; several large stage 4 decubitus ulcers

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☑ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] SEEMA NOUR
29c. License number:
29d. Date signed (Month, Day, Year): 12, 14, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHNS HOPKINS BAYVIEW MEDICAL CENTER, 4940 EASTERN AVENUE, BALTIMORE

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature: [signature]

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene 2003 41310

1- For State Registrar

# Certificate of Death

Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| SYLVIA | SALAWITCH | DECEMBER 17, 2003 | 10:20 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SINAI HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-20-0259 | 1☐ M 2☑ F | 77 Yrs. | | | FEB. 13, 1926 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☑ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3411 OLYMPIA AVENUE | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced | 1☐ Yes 2☑ No If Yes, Give Year or Dates: | 1☐ Yes 2☑ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 1 | OWNER | HALLMARK CARD STORE |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| ABRAHAM | SILVERMAN | LILLIAN | HETTLEMAN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| LEE SALAWITCH / SON | 3009 - J ROMARIC COURT - BALTIMORE, MD 21209 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | SHARD TIFERETH ISRAEL ANSHE | 12/19/2003 | ROSEDALE, MD |

21. Signature of Funeral Service Licensee ▶ Scott M. Cattlin

22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

RESPIRATORY FAILURE

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | LES - 000 | DECEMBER 17, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J.A. YOITO MD, 2401 W BELVEDERE AVE, BALTIMORE, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

SALAWITCH, SYLVIA

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41311

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dolores K Smith
2. Date of Death: Month 12 Day 18 Year 2003
3. Time of Death: 4:15 pM
4a. Facility Name (If not institution, give street and number): 3434 Dunran Rd.
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-32-2818
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Nov. 5, 1935
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 3434 Dunran Rd.
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yrs. | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): John D'Alesandro
18. Mother's Name (First, Middle, Maiden Surname): Dolores Harper

19a. Informant's Name/Relationship (Type, Print): william Smith husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3434 Dunran Rd. Dundalk Md. 21222

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cem.
Date: Dec 22, 2003
20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Diabetes
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
orthostatic hypotension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Scott Feeser
29c. License number: D42232
29d. Date signed (Month, Day, Year): 12/19/03
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Feeser 2112 Dundalk Ave Baltimore MD 21222

**State Registrar**

31. Date filed (Month, Day, Year): DEC 20 2003
32. Registrar's Signature: [signature]

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Medical Certification: To be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41312

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Fannie Tyson
2. Date of Death: Month 12 Dey 17 Year 2003
3. Time of Death: 8:50 AM
4a Facility Neme (If not institution, give street and number): Long Green 115 E. Melrose Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 242-17-3673
6. Sex: 1☐ M 2■ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-11-1914
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1■ Yes 2☐ No
10e. Street and Number: 115 E. Melrose Avenue
10f. Zip Code: 21212
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3■ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2■ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2■ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): James Glover
18. Mother's Name (First, Middle, Maiden Sumame): Elizabeth Glover

19a. Informant's Name/Relationship (Type, Print): Cassandra Lucas/ Guardian
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 Cathedral St. Baltimore, MD 21201

20a. Method of Disposition: 1■ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt.Zion Cemetery
Date: 12-22-03
20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Wylie Funeral Home 638N. Gilmor St. Baltimore, MD

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — Minutes
Due to (or as a consequence of):
b. Ischemic cardiomyopathy — years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contributa to tha cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examinar**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D17118
29d. Date signed (Month, Day, Year): Dec 18, 2003

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Paul Schwartz M.D. 7700 York Rd 21204

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requiras that tha daath certificate be executed within 24 hours afar daath.
To the Funeral Director: After this cartificata has been signed by the attending physician and completaly filled in by the funeral director, paga 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41313

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): SABATINO TRIONFO, SR

2. Date of Death (Month, Day, Year): DEC 18 2003

3. Time of Death: 7:30 AM

4a. Facility Name (If not institution, give street and number): 9503 PERRY HALL BLVD.

4b. City, Town, or Location of Death: PERRY HALL

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 214-03-3992

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 23, 1918

9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: PERRY HALL

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 9503 PERRY HALL BLVD.

10f. Zip Code: 21236

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: U.S. ARMY

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONTRACTOR

16b. Kind of Business/Industry: Self.

17. Father's Name (First, Middle, Last): JOSEPH TRIONFO

18. Mother's Name (First, Middle, Maiden Surname): GIOVANNA ALLORO

19a. Informant's Name/Relationship (Type, Print): MARY TRIONFO (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9503 PERRY HALL BLVD. BALTO. MD 21236

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer cem

Date: 12/22/03

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: ▶ Paul M. Stella

22. Name and Address of Facility: HARTLEY MILLER — STELLA FUNERAL HOME CH'TD. 7527 HARFORD RD. BALTO MD 21234

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 2 MONTHS

Immediate Cause (Final disease or condition resulting in death)

a. A.M. LEUKEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ JR Purtell

29c. License number: D19714

29d. Date signed (Month, Day, Year): 12/18/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MILHARI PURTELL 8114 SANDPIPER CIRCLE SUITE 211 BALTIMORE Md 21236

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature: ▶ Jeanne B. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41314

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Sarah L. Tracey
2. Date of Death Month Day Year: December 16 2003
3. Time of Death: 3:43 PM
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-36-4292
6. Sex: 1 ☐ M 2 ☑ F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 10, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 536 E. 22nd Street
10f. Zip Code: 21218
10g. Citizen of What Country?: United States of America

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeping
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Paul Kelly
18. Mother's Name (First, Middle, Maiden Surname): Bessie

19a. Informant's Name/Relationship (Type, Print): Terry E. Hawkins/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 621 St. Ann Ave. Balto., MD 21218

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Carmel
Date: Dec. 23, 2003
20c. Location - City or Town, State: Balto., MD

21. Signature of Funeral Service Licensee: [signature] Miller
22. Name and Address of Facility: Miller's Metropolitan Chapel 1639 N. Broadway Balto MD 21213

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Cancer — Approximate Interval: 6 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Edith Rayfield, MD Medical Resident
29c. License number: AT2438946
29d. Date signed (Month, Day, Year): December 16 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edith Rayfield MD 201 East University Parkway Baltimore, MD 21218

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

UNK 03-057
03-01195-510
RKD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41315

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Unknown 03-057 | MARCH 4, 2003 | 4:05P. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 4915 GOODNOW ROAD | BALTIMORE | |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| unk | 1☒M 2☐F | unk Yrs. | | | unk | unk |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4915 Goodnow Road | 21206 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| unk 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☐No unk If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | unk | unk |
| unk | unk | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| unk | unk |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| O.C.M.E. | 111 Penn Street Baltimore, MD 21201 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Undetermined

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined | Unknown | Unk. M | 1☐Yes 2☒No | Unknown |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State): Unknown

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | O.C.M.E. | MARCH 5,2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Kelly 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

PM
3-01080-510
NK. 03-051

Amend 1,5,7,8,9,10,11,12,13,14,15,16,17,18,19 per ct order G914 4/6/11 dk

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1 - For State Registrar

Reg. No. 2003 41316

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ~~Unknown 03-051~~ **Matthew Jon Ward**

2. Date of Death (Month, Day, Year): February 26, 2003

3. Time of Death: 19:55 M

4a. Facility Name (If not institution, give street and number): 612 Pitcher Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: ~~unk~~ 561-17-4199

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): ~~unk~~ 32 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~unk~~ 2/21/1971

9. Birthplace (State or Foreign Country): ~~unk~~ CA

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: ~~unk~~ MD

10b. County: ~~unk~~ Baltimore

10c. City, Town or Location: ~~unk~~ Owings Mills

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: ~~unk~~ 9014 Groffs Mill Drive

10f. Zip Code: ~~unk~~ 21117

10g. Citizen of What Country? ~~unk~~ USA

11. Marital Status: ~~unk~~ 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No ~~unk~~ If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ~~unk~~ 12 — College (1-4or 5+): ~~unk~~

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ~~unk~~ Writer

16b. Kind of Business/Industry: ~~unk~~ Self-employed

17. Father's Name (First, Middle, Last): ~~unk~~ Bruce Lynn Ward

18. Mother's Name (First, Middle, Maiden Surname): ~~unk~~ Rosemary Alice Wagner

19a. Informant's Name/Relationship (Type/Print): ~~Rosemary Alice~~ O.C.M.E. Ward Mack/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~111 Penn Street Baltimore, MD 21201~~ 19944 Choctaw Court, Germantown MD 20876

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypothermia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Narcotic use

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day Year): FOUND 2-26-03

28b. Time of: FOUND 7:55 PM

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: EXPOSED TO COLD ENVIRONMENTAL TEMPERATURES

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): VACANT HOUSE

28f. Location (Street and Number or Rural Route Number, City or Town, State): 612 PITCHERS STREET, BALTO., MD.

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M. Titus

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): February 27, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 2 2 2003

32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41317

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Vera Levinson Volner
2. Date of Death (Month, Day, Year): December 6, 2003
3. Time of Death: 1:32 P M
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 067-09-2838
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 14, 1910
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5721 Grosvenor Lane
10f. Zip Code: 20814
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): College Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Isadore Levinson
18. Mother's Name (First, Middle, Maiden Surname): Tina Strizver

19a. Informant's Name/Relationship (Type, Print): Kelcey Roth / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10106 Walker Woods Dr., Great Falls, VA 22066

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sharon Gardens Cemetery
Date: 12/16/03
20c. Location - City or Town, State: Valhalla, NY

21. Signature of Funeral Service Licensee: Dennis Pittman
22. Name and Address of Facility: Beecher Funeral Home 418 Bedford Rd., Pleasantville, NY 10570

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Septic Shock
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Dehydration
Due to (or as a consequence of):
d. Coagulopathy

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atrial fibrillation
Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Gita Bakshi
29c. License number: D 23170
29d. Date signed (Month, Day, Year): December 6, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gita Bakshi, M.D. 8600 Old Georgetown Rd., Bethesda, MD 20814

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

VOLNER, VERA 12/6/03 1332

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For Stete Registrar

Reg. No. 2003 41318

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JULIA CHRISTIAN VAUGHN | DEC 6 2003 | 11:57 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| NATIONAL NAVAL MEDICAL CENTER | BETHESDA | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | If Under 1 Year: Days | If Under 24 Hrs.: Hours | If Under 24 Hrs.: Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 219-67-4667 | 1☐M 2☒F | Yrs. | 1 | 23 | | | Oct 14, 2003 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Gunpowder | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1129 A Severn Court | 21010 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| none | | none | none |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Elton Benjamin Vaughn | Carola Dee Osborn |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ben Vaughn | 1129 A Severn Court Gunpowder, MD 21010 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Resthaven Mem. Park | 12-12-03 | Lubbock, Texas |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Resthaven Funeral Home 5740 West 19th Lubbock, TX 79407

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. E COLI MENINGITIS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] MD | D0044634 | 12/08/03 |

| 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) | |
|---|---|
| JEFFREY R. GREENWALD CAPT MC USN | NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 |

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41319

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LOUIS JOHN VENANZI
2. Date of Death (Month, Day, Year): December 17, 2003
3. Time of Death: 6:30P M
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-18-3891
6. Sex: XX 1 M 2 F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 24, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 Yes 2 XX No
10e. Street and Number: 6932 Eastbrook Avenue
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married XX Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance Mechanic
16b. Kind of Business/Industry: Nursing Home

17. Father's Name (First, Middle, Last): Louis John Venanzi
18. Mother's Name (First, Middle, Maiden Surname): Julia DiCarlontonio

19a. Informant's Name/Relationship (Type, Print): Robert L Venanzi Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 518 Windwood Road Baltimore, Maryland 21212

20a. Method of Disposition: XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer
Date: 12/20/03
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Dennis Stephen Kenakis
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finat disease or condition resulting in death)
a. pneumonia
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. hepatocellular Carcinoma
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval 8etween Onset and Death
a. days
b. months

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was en autopsy performed? 1 Yes 2 No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No
26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D 58303
29d. Date signed (Month, Day, Year): December 17 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Aaron J. Charles MD 6601 N. Charles St Baltimore MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Venanzi, Louis 12/17 @ 6:30pm

4

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item#12perFHG826 12/22/03 EW

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41320

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| William | Watson | December 16 03 | 9:00a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3920 Oakford Ave | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 250-54-0741 | X 1 M 2 F | 67 Yrs. | | | 08 29 36 | SC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3920 Oakford Ave | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 X Widowed 4 Divorced | 1 X Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | na | Youth Supervisor | State Of Maryland |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Unknown | Susan Wicks |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25401 |
|---|---|
| William Gerald Watson-Son | 331 Pendleton Drive Apt G, Martinsburg, WV |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Garrsion Forest Vet. | 12/29/03 | Owings Mill, Md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Rebecca E. Hyre | March F/H West 4300 Wabash Ave, Baltimore Md 21215 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. AMYOTROPIC LATERAL SCLEROSIS | 2 YEARS |
| Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 X No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 Yes 2 X No 3 Probably 4 Unknown | 1 Yes 2 X No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 X No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 X Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D29071 | 12/17/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type or Print) B. HAMADA 4 NORTH 8TH N. ENTRANCE BALTIMORE MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Brandon Wilson
03-08057
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41321

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|---|
| Brandon | Wilson | December 14, 2003 | 3:30 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical Center | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-02-4889 | 1 [X] M 2 [ ] F | 20 Yrs. | | | 3-11-83 | Md. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | NA | Baltimore | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1007 W. Lanvale Street | 21217 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8th grade | | Chef | Personel Plus |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Antonio Wooden | Dekota Wilson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dekota Wilson Mother | 1007 W. Lanvale St., Baltimore, Md. 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Greenmount Cem. | 12-22-03 | Baltimore, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gladys Wane | March F.H. East 1101 E. North Ave. Baltimore, Md. 21202 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Gunshot Wound of Head | |
| Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (Specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [X] Yes 2 [ ] No | 1 [X] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 [X] Yes 2 [ ] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 12-12-2003 | 10:24 A M | 1 [ ] Yes 2 [X] No | Subject was shot. |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Street | 600 Block North Carrollton Avenue, Baltimore, Maryland |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Ling Li, M.D. | O.C.M.E. | December 16, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ling Li, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41322

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| William | Howard | Warren | December 20 2003 | 10:10 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 12323 Manvel Lane | Bowie | Prince Georges |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577-42-2661 | 1 [X] M 2 [ ] F | 70 Yrs. | | | Feb. 16, 1933 | Washington DC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince Georges | Bowie | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12323 Manvel Lane | 20715 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married [X] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1955-57 | 1 [ ] Yes [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Carpenter | Giant Food |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Foster Warren | Susie Tyler Creel |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mark L. WArren (Son) | 12323 Manvel Lane, Bowie, MD 20715 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Metro Crematory | 12/24/2003 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. COPD | 5 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): CHF | 1 year |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Smoking Alcohol abuse

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D0052089 | 12/22/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ruth Gallatin, MD 2401 Brandermill Blvd #220 Gambrills MD 21054

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41323

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ruth Harriet WASSERMAN
2. Date of Death (Month, Day, Year): December 18 2003
3. Time of Death: 202p M
4a. Facility Name (If not institution, give street and number): 15211 EIKRIDGE WAY
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 082-12-8327
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 2, 1922
9. Birthplace (State or Foreign Country): NEW YORK

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: md
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 15211 EIKRIDGE WAY
10f. Zip Code: 20906
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): MAX BARACK
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): JUDY GARSON (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15211 EIKRIDGE WAY SILVER SPRING MD 20906

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): West Arundel Cemetery
Date: December 23, 03
20c. Location - City or Town, State: Odenton, MD

21. Signature of Funeral Service Licensee: Juanita R Thomas
22. Name and Address of Facility: Anatomy Gifts Registry 7526 Connelly Dr Hanover MD 21076

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Cardio Pulm - Arrest
Due to (or as a consequence of): b. Metastatic Carcinoma of the Colon
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Howard J Schatten MD
29c. License number: D 20388
29d. Date signed (Month, Day, Year): Dec. 19, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4701 Randolph Rd. Rockville, md. 20852

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41324

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Gerald J. Winnick | December 16 2003 | 5:12 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Union Hospital | Elkton | Cecil |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 210-28-2562 | 1☑ M 2☐ F | 66 Yrs. | | | July 25, 1937 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Cecil | Rising Sun | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 507 Telegraph Road | 21911 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Fork Truck Driver | Auto Manufacturing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Grover S. Winnick | Gertrude Thompson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gerald J. Winnick, Jr./Son | 295 Shady Beach Road, North East, MD 21901 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Brookview Cemetery | 12-20-2003 | Rising Sun, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Richard L. Goodie | R.T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD 21911 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Myocardial Infarction | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alcoholism

Carotid Artery Stenosis

Acute renal failure

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Neil E. Lattin | D0058354 | 12/17/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil E. Lattin
101 Colonial Way, Rising Sun, Maryland, 21911

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41325

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: Joyce Jacquetta Wagner

2. Dete of Death Month / Day / Yeer: December 16, 2003

3. Time of Death: 859p

4a Fecility Name *(If not institution, give street end number)*: Stella Maris

4b. City, Town, or Location of Death: Baltimore

4c. County of Deeth: Baltimore

**Funeral Director**

5. Social Security Number: 220-38-5447

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthdey)*: 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 05/04/1942

9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 3023 Strickland Street

10f. Zip Code: 21223

10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Rep. Credit Union Member Service

16b. Kind of Business/Industry: Banking

17. Fether's Neme *(First, Middle, Last)*: Edward H. Hudgins

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary M. Gayleard

19a. Informant's Name/Relationship *(Type, Print)*: Mark Dorsey/son

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 3023 Strickland Street Baltimore,MD 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: Loudon Park Cemetery

Date: 12/20/03

20c. Location - City or Town, State: Baltimore,Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ambrose Funeral Home,Inc. 1328 Sulphur Spring Rd. Arbutus,Maryland 21227

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)* hospice

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as steted. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature end title of certifier: [signature] MD

29c. License number: D40854

29d. Date signed *(Month, Dey, Year)*: 12/17/2003

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): David Rischbieter 301 St Paul Pl Baltimore 21202

**State Registrar**

31. Dete filed *(Month, Dey, Year)*: DEC 22 2003

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41326

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| William Ronald Weaver | December 18 2003 | 5:45 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 15020 Laureland Place | Laurel | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 529-46-2373 | 1☒M 2☐F | 63 Yrs. | | | Jan. 7, 1940 | Utah |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince George's | Laurel | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15020 Laureland Place | 20707 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No 1958-1962 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | Ø | Clerk | US Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James D. Weaver | Irene Mildred Walker |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Carolyn Weaver/Wife | 15020 Laureland Place, Laurel, MD 20707 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify) | Myers Evergreen Cem. | 12/23/2003 | Ogden, Utah |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Laurie Donaldson M00160 | Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Deep Venous Thrombosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Back Pain

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D0017135 | December 18, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Swink, 8871 Gorman Road, Laurel, MD 20723

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41327

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): A. Marvin Webb, Jr.
2. Date of Death (Month, Day, Year): DEC. 21, 2003
3. Time of Death: 3:10a M
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-40-7508
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 26, 1941
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1630 Calvert Street
10f. Zip Code: 21202
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Baltimore City Public Schools

17. Father's Name (First, Middle, Last): A. Marvin Webb, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Miriam R. Bailey

19a. Informant's Name/Relationship (Type, Print): Richard T. Webb/brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 616 Coachman Way Parkton, MD 21120

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 12-22-03
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. end-stage liver disease, secondary to — Approximate Interval Between Onset and Death: years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Hepatitis C — Due to (or as a consequence of): — years
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Acquired immuno deficiency Syndrome

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): December 21, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Webb, Marvin 12-21-03 0310

6

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41328

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| EDWARD AUGUST WEINEL | December 20, 2003 | 3:20 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PICKERSGILL RETIREMENT COMMUNITY | Towson | Baltimore County |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 705-10-8610 | 1☒ M 2☐ F | 96 Yrs. | | | Jul 27, 1907 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore County | Towson | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 615 Chestnut Avenue, #1321 | 21204 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Accounting Supervisor | Railroad |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Gottlieb Weinel | Henrietta Hagen |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Bruce C. Weinel (Son) | 32 Oakway Road, Timonium, Maryland 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Moreland Memorial Park | 12/23/2003 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Martin D. Lawson | Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. recurrent asp. pt. in pneumonitis | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive lung disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ W. Anthony Riley, MD | D25205 | December 20, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | ▶ |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 17 Rev 1/2001

ORIGINAL

DOS
03-8067
Robin Braxton-Williams

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM 23a,27728a-f PER ME G827 1/05/04 JB

# Certificate of Death

Reg. No. 2003 41329

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robin Braxton-Williams
2. Date of Death (Month, Day, Year): December 15 2003
3. Time of Death: 455 a M
4a. Facility Name (If not institution, give street and number): University Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

2846

5. Social Security Number: 214-76-9704
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 44 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-28-59
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County:
10c. City, Town or Location: BALTO.
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 808 N. Streeper ST.
10f. Zip Code: 21205
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 13th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Russell Stanley
18. Mother's Name (First, Middle, Maiden Surname): Minnie Braxton

19a. Informant's Name/Relationship (Type, Print): ERIC Williams Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 808 N. Streeper ST. BALTO. Md. 21205

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARbutus Mem
Date: 12-23-03
20c. Location - City or Town, Stete: ARbutus Md.

21. Signature of Funeral Service Licensee: Wesley Chavis
22. Name and Address of Facility: Wesley CHAVIS JR. FUNERAL HOME 2123 2067 Eastern Ave. BALTO. Md.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☒Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation ☒Could not be determined
28a. Date of Injury (Month, Day Year): found 12-14-03
28b. Time of Injury: found 12:30a M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): RESIDENCE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 808 STREEPER ST, BALTIMORE, MD.

29a. Certifier (Check only one) 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: OCME
29d. Date signed (Month, Day, Year): December 16 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

Antonio Yerby
03-08087
RJD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM23a&27 PER ME G827 1/09/04 JH

# Certificate of Death

Reg. No. 2003 41330

2847

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Antonio | Yerby | December 16, 2003 | 0424A. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Johns Hopkins Hospital | Baltimore | NA |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | If Under 1 Year: Days | If Under 24 Hrs.: Hours | If Under 24 Hrs.: Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 215-57-7909 | 1 [X] M 2 [ ] F | 2 Yrs. | 8 | 15 | | | 3-1-00 | Md. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | NA | Baltimore | [X] 1 Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2042 E. Fayette St. | 21230 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| Infant | | Infant | NA |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Anthony Yerby | Rochelle Thomas |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Rochelle Thomas Mother | 2042 E. Fayette St., Baltimore, Md. 21230 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Voshell Mem. Garden | 12-20-03 | Dundalk, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gladys Warner | March F.H. East 1101 E. North Ave. Baltimore, Md. 21202 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. INFLUENZA A VIRUS INFECTION COMPLICATED BY HEMOPHILUS INFLUENZAE SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Patricia Aronica-Pollak MD

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) December 16, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICIA ARONICA-POLLAK MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year) DEC 22 2003

32. Registrar's Signature ▶

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41331

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Margaret, Young | December, 18 2003 | 01:30 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Greater Baltimore Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-34-0544 | 1☐M 2☒F | 65 Yrs. | | | AUG 10, 1938 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Lutherville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 300 W. Seminary Avenue | 21093 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Lab Technician | Healthcare |
| | 4 | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frederick Maisel, III | Helen Kirwan |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Anthony J. Young, Jr./son | 7336 Greenbank Road Baltimore, MD 21220 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Crematory, Inc. | 12/19/03 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Dawn F. McDonald | Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarctions | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ George Bedow MD | D12732 | 12/18/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GEORGE A. BEDOW MD 6701 N. Charles St. Baltimore, MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 22 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

Young, Margaret
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41332

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| John Franklin Ausherman | December 1 2003 | 1650 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington County Hospital | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-24-6140 | 1☒M 2☐F | 75 Yrs. | | | March 31, 1928 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 44 East Antietam Street Apt. 1 | 21740 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | Sandblasting Co. | Final Assembler |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Daniel E. Ausherman | Rachel Catherine Blickenstaff Rinehart |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard Hammer/ Brother in-law | 21734 Ringgold Pke. Hagerstown Maryland 21740 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Cedar Lawn Mem. Park | Dec. 5, 2003 | Hagerstown, Maryland |

21. Signature of Funeral Service Licensee: ▶ Douglas A. Fiery

22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Maryland 21742

Ausherman, John

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sick Sinus Syndrome

Due to (or as a consequence of):
b. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Aortic stenosis

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D0060396

29d. Date signed (Month, Day, Year): 12/2/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FARID MURSHED 1126 Opal Ct Hag. Md 21742

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

31. Date filed (Month, Day, Year): DEC 08 2003

32. Registrar's Signature: ▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41333

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Abraham Guy Bowers | December 4 2003 | 1810 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington County Hospital | Hagerstown, | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-50-7792 | 1 [X] M 2 [ ] F | 53 Yrs. | | | Mar. 4, 1950 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Washington | Hagerstown, | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11526 French Lane | 21740 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | 0 | service technician | Paint & Glass Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles B. Bowers | Cyntha S.E. Fox |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Doreen K. Bowers wife | 11526 French Lane Hagerstown, MD 21740 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Greenlawn Cemetery | Dec. 9, 2003 | Williamsport, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Donald Edwin Thompson Funeral Home, Inc P.O.Box 310 Clear Spring, MD 21722 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | 5 min |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Atherosclerotic Vascular Disease | |
| | Due to (or as a consequence of): c. Hyperlipidemia. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 [ ] Yes 2 [ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and Title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] Mary E Money MD | D 23815 | 12/5/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Money 354 Mill Street Hagerstown Maryland

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 08 2003 | [signature] |

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ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-I show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

H3050039043

GH-5

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41334

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| RUTH NAOMI BAUMGARDNER | December 15 2003 | 7:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Glade Valley Nursing & Rehab. | Walkersville | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-16-0168 | 1☐M 2☒F | 90 Yrs. | | | Sept. 28, 1913 | North Dakota |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Carroll | Taneytown | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 337 East Baltimore Street | 21787 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Seamstress | Clothing Manufacturer |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Thomas C. LeGore | Mary Eliza Forney |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ronald N. Baumgardner/son | 506 N. Fairfax Blvd., Ranson, WV 25438 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Trinity Lutheran Cem. | Dec. 19, 2003 | Taneytown, MD |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| John M. Skiles | M00534 | Skiles Funeral Home 136 E. Baltimore St., Taneytown, MD 21787 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 1 week |
| Due to (or as a consequence of): | b. Congestive Heart Failure | 1 week |
| Due to (or as a consequence of): | c. | |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D43091 | 12-15-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAEED ZAIDI MD 801 Toll House Ave, Frederick, MD 21701

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | [signature] |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41335

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Nancy Jean Bosley
2. Date of Death: Month December, Day 15, Year 2003
3. Time of Death: 0650
4a. Facility Name (If not institution, give street and number): 17150 Bullfrog Road
4b. City, Town, or Location of Death: Taneytown
4c. County of Death: Carroll County

**Funeral Director**

5. Social Security Number: 219-50-4400
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Yeer): May 31 1946
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll County
10c. City, Town or Location: Taneytown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17150 Bullfrog Road
10f. Zip Code: 21787
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired): produce clerk
16b. Kind of Business/Industry: grocery store

17. Father's Name (First, Middle, Last): Sherman Floyd Cutlip
18. Mother's Name (First, Middle, Maiden Sumame): Zena Catherine Hall

19a. Informant's Name/Relationship (Type, Print): Clarence Bosley / husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 17150 Bullfrog Road Taneytown, Maryland 21787

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Mem. Park
Date: Dec 22 2003
20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: ▶ Alan C. Parris
22. Name and Address of Facility: Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast Cancer
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
UnKnown

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Howard Saratz, M.D.
29c. License number: Md. # D15552
29d. Date signed (Month, Day, Yeer): 12/16/03

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Howard Saratz MD 555 South Center Street Westminster MD 21157

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: ▶ [signature]

**To the Hospital or Attending Physician:** Tha law raquiras that tha death certificata be executed within 24 hours after death.
**To the Funeral Director:** After this certificata has been signed by tha attanding physician and compleialy fillad in by tha funaral director, paga 2 should be datached for usa as tha burial-transit

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar: Amended #14 WCHD/SH 12/8/03 as per FH

# State of Maryland / Department of Health and Mental Hygiene
# Certificate of Death

Reg. No. 2003 41336

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Kevin Michael CHUNG | 12 / 03 / 2003 | 6:00a.m. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1016-A Noland Drive | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 072-54-0402 | 1☒M 2☐F | 44 Yrs. | | | Sept.10,1959 | New York |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 220 N. Jonathan Street | 21740 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: ~~white~~ Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | mail carrier | city |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Fitzgerald Robert Chung | Dorothy Elizabeth Campbell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Vivian Green - life partner | 1016-A Noland Dr., Hagerstown, Md. 21740 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Rose Hill Cemetery | 12/8/03 | Hagerstown, Maryland |

21. Signature of Funeral Service Licensee: Scott M Minnich

22. Name and Address of Facility: MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiac Arrythmias | minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Atrial Fibrillation / Flutter | Years |
| | c. Due to (or as a consequence of): Cardiomyopathy | Years |
| | d. Due to (or as a consequence of): congestive Heart Failure | Years |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPOTENTION
Hepatitis C +VE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) PARTNERS HOME

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) / 28b. Time of Injury / 28c. Injury at Work? 1☐Yes 2☐No / 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) / 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D45031 | Dec 3 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 19414-C CLOPPERSBURG PLACE HAGERSTOWN MD 21742

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 05 2003 | Karen A. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SH-3

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #5 PER FH G826 12/22/03 JH

# Certificate of Death

Reg. No. 2003 41337

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Sarah Catherine Clingan | December 14 2003 | 12:05 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Catherine's Nursing & Rehab. Ctr. | Emmitsburg | Frederick County |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| ~~218-09-2236~~ 218-09-2235 | 1☐ M 2☒ F | 91 Yrs. | | | July 10 1912 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Carroll County | Taneytown | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 204 Carroll Heights | 21787 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | manager | retail store |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Albert Baker | Mary Margaret Curfman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Harry E. Clingan / husband | 204 Carroll Heights Taneytown, Maryland 21787 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Grace UCC Cemetery | Dec. 18 2003 | Taneytown, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Alan C. Penn | Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Endstage Dementia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Alzheimers | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Bonita J Krempel-Portiendo | H44037 | 12/14/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BONITA J KREMPEL-PORTIENDO 52 WATER STREET BOX 1 THURMONT, MD 21788

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | Geneva E Coats |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41338

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Russell Davis, Sr.
2. Date of Death: Month 12 Day 02 Year 2003
3. Time of Death: 5:30 PM
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington county

**Funeral Director**

5. Social Security Number: 212-38-7874
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 8 1939
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 146 Ray Street
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cabinet Marker
16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Harry Calvin Davis
18. Mother's Name (First, Middle, Maiden Surname): Amanda Brown Davis

19a. Informant's Name/Relationship (Type, Print): Virginia Lee Davis/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 146 Ray Street Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Mem. Park
Date: Dec.6, 2003
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Douglas A. Fiery
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd. Hagerstown, Maryland 21742

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. PULMONARY EMBOLISM

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. DEEP VEIN THROMBOSIS.
Due to (or as a consequence of): c. CHRONIC ULCERS.
Due to (or as a consequence of): d. CHRONIC OBSTUCTIVE PULMONARY DISEASE

Approximate Interval Between Onset and Death: a. ; b. YEARS ; c. YEARS ; d. YEARS.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Increase in Cholesterol

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? M 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D45031.
29d. Date signed (Month, Day, Year): Dec 08 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 19414-C LEITERSBURG PIKE HAGERSTOWN MD 21742

**State Registrar**

31. Date filed (Month, Day, Year): DEC 08 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41339

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Mildred Scheel Davis | December 15, 2003 | 1830 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Wilson Health Care Center | Gaithersburg | Montgomery County |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 218-12-2855 | 1☐ M 2☒ F | 107 Yrs. | | | | | Sep. 1 1896 | New York |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Linthicum Heights | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 304 East MAple Road | 21090 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | bookkeeper | accounting |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Howard Scheel | Susie Reinig |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gordon L. Davis / son | 3261 Hyser Road Taneytown, Maryland 21787 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Smithsburg Crematorium | Dec. 17 2003 | Smithsburg, Maryland |

21. Signature of Funeral Service Licensee: Alan C. Purvis

22. Name and Address of Facility: Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Heart Disease — Due to (or as a consequence of): — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism
Upper Respiratory Infection

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D33357 | 12/16/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lee Jonathan Musher MD 5530 Wisconsin Ave Chevy Chase, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41340

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Wallace Hallowell Dickson | December 12 2003 | 2130 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 46 Marlyn Drive | Elkton | Cecil |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 201-12-0281 | 1☒ M 2☐ F | 81 Yrs. | | | FEB 1, 1922 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Cecil | Elkton | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 46 Marlyn Drive | 21921 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Year or Dates: World War II | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Sales Representative | Scientific |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Aubrey C. Dickson | Bertinia Hallowell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Barbara D. Dickson/Wife | 46 Marlyn Drive, Elkton, Maryland 21921 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | R.A. Ferris & Co. Inc. | December 15, 2003 | West Chester, Pennsylvania |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Donald S. Hicks | Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. prostate cancer | 3 years |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ | H0054380 | 12/16/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christie E.K Hoch, D.O 42 Suburban Plaza Newark, Delaware 19711

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

14 X1

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41341

Physician /Medical Examiner

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Ralph | NMI | Eggebrecht | December 7, 2003 | 22:00 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington County Hospital | Hagerstown | Washington |

Funeral Director

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 397-28-0739 | 1 [X] M 2 [ ] F | 72 Yrs. | | | October 26, 1931 | Wisconsin |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Washington | Hagerstown | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11823 Patrick Road | 21742 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 3 | Linotype Operator | Publishing House |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Otto Eggebrecht | Alfreda Kopitzke |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Virginia I. Eggebrecht/Wife | 11823 Patrick Road, Hagerstown, MD 21742 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Rest Haven Cemetery | 12/11/2003 | Hagerstown, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ F. Mark Sipe | Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 |

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Renal Failure | 10 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Multiple Myeloma | 9 Months |
| | c. | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 [ ] Yes 2 [ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurrad at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. Licensa number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Michael J. McCormack MD | D 41667 | 12-8-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr McCormack 11110 Medical Campus Rd Hag. MD 21742

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | ▶ Sharon D. Spotts |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41342

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Thelma A. Ebaugh | Dec. 12 2003 | 8:40 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Progress Unlimited | Randallstown | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-62-3826 | 1☐M 2☒F | 84 Yrs. | | | Feb. 8, 1919 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Randallstown | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3707 McDonough Road | 21133 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 0 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumeme) |
|---|---|
| Jacob E. Ebaugh | Katie Bowman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 |
|---|---|
| Robert B. Ebaugh / Son | 11606 Greenspring Ave. Lutherville, MD |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) Date | 20c. Location - City or Town, State |
|---|---|---|
| 1☒Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify) | New Freedom Cemetery Dec. 16, 2003 | New Freedom, PA |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second Street New Freedom, PA 17349

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. pneumonia — Due to (or as a consequence of): — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Dementia — Due to (or as a consequence of): — years
c. — Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D07421 | 12/15/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1838 Greene Tree Rd #300 21208

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | [signature] |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41343

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Paul Myron Fryer

2. Date of Death: Month Dec. Day 4 Year 2003

3. Time of Death: 01:55 p M

4a. Facility Name (If not institution, give street and number): Homewood Retirement Center

4b. City, Town, or Location of Death: Williamsport

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 213-12-7069

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06/11/1922

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Williamsport

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 16505 Virginia Avenue

10f. Zip Code: 21795

10g. Citizen of What Country?: us

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vice President

16b. Kind of Business/Industry: Hosiery

17. Father's Name (First, Middle, Last): Paul Henry Fryer

18. Mother's Name (First, Middle, Maiden Surname): Margaret A. Lindauer

19a. Informant's Name/Relationship (Type, Print): Iris Fryer / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16505 Virginia Ave., Williamsport, MD 21795

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rose Hill Cemetery

Date: 12/08/2003

20c. Location - City or Town, State: Hagerstown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street, Hagerstown, MD 21740

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. END STAGE PARKINSONISM

Approximate Interval Between Onset and Death: 3-5 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): b.

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MEDICAL DIRECTOR

29c. License number: D7006

29d. Date signed (Month, Day, Year): 12/4/2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEPHEN C. METZLER, MD 747 NORTHERN AVE HAGERSTOWN, MD 21742

**State Registrar**

31. Date filed (Month, Day, Year): DEC 08 2003

32. Registrar's Signature

---

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Paul Fryer

12/4/03 1:55pm

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41344

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Mary Constance GRABER | December 4 2003 | 12:39 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington County Hospital | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-16-3349 | 1☐ M 2☒ F | 81 Yrs. | | | Jan. 7, 1922 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 13531 Cherry Tree Circle | 21742 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | teller | bank |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William C. Martin | Olive E. Martin |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| William Wantz, Esq.-Executor | 123 W. Washington St., Hagerstown, Md. 21740 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Hagerstown Crematory | 12/5/03 | Hagerstown, Maryland |

21. Signature of Funeral Service Licensee ▶ Scott M Minnich

22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Bilateral pneumonia | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Due to (or as a consequence of): | | |
| c. Due to (or as a consequence of): | | |
| d. | | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis Livers
Alcohol Dependeneee
Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Tommy MD | D 41786 | 12/5/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Hencherg MD 12821 Oak Hill Ave, Hagerstown MD 21742

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 08 2003 | ▶ Steven D. Sparks |

**State Registrar**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41345

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Sue Elizabeth Gruber | December 3, 2003 | 6:00 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 18913 Rolling Road | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-09-8434 | 1☐ M 2☒ F | 86 Yrs. | | | July 28, 1917 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Washington | Hagerstown | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 18913 Rolling Road | 21742 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Teacher | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Victor E. Linder | Lida H. Dellinger |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Albert S. Gruber/Husband | 18913 Rolling Road, Hagerstown, MD 21742 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Rest Haven Cemetery | 12/9/03 | Hagerstown, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ S. Mark Snipp | 1601 Pennsylvania Ave. Rest Haven Funeral Chapel Hagerstown, MD 21742 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Cardiomyopathy — Approximate Interval: 2 yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic vascular Disease

Due to (or as a consequence of):

c. Hyperlipidemia

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Mary E Money MD | DZ3815 | 12.4.03. |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary E. Money, MD 354 Mill Street, Hagerstown, MD 21740

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 08 2003 | Karen B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

54-5

DOS
03-6622
Gary T. Horsey

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM 23a&27 PER ME G826 12/23/03 lb

# Certificate of Death

Reg. No. 2003 41346

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gary Troy Horsey

2. Date of Death (Month, Day, Year): October 17 2003

3. Time of Death: 1018 M

4a. Facility Name (If not institution, give street and number): Delmar Inn

4b. City, Town, or Location of Death: Delmar

4c. County of Death: Wicomico

**Funeral Director** 1933

5. Social Security Number: 221-54-0072

6. Sex: 1☐M 2☐F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-26-1962

9. Birthplace (State or Foreign Country): Laurel Del.

Usual Residence of Decedent

10a. State: DEL.

10b. County: Sussex

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: P.O.Box 433

10f. Zip Code: 19956

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Spin Operator

16b. Kind of Business/Industry: Dupont

17. Father's Name (First, Middle, Last): Charles Horsey

18. Mother's Name (First, Middle, Maiden Surname): Juanita Williams

19a. Informant's Name/Relationship (Type, Print): Irma A. Horsey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.Box433 Laurel Delaware 19956

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Veteran Memorial

Date: 10-22-03

20c. Location - City or Town, State: Millsboro Delaware

21. Signature of Funeral Service Licensee: Joanne A Moore

22. Name and Address of Facility: Youngs Funeral Home 309 North Street Milford Delaware 19963

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. DIABETIC KETOACIDOSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie Dr Yvell MD

29c. License number: OCME

29d. Date signed (Month, Day, Year): October 18 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARJORIE D. KOBELL 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 22 2003

32. Registrar's Signature: Barbara A Groves

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## *Certificate of Death*

Reg. No. 2003 41347

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: REYNOLDS SYLVESTER HANES

2. Date of Death — Month: NOV Dey: 16 Year: 2003

3. Time of Death: 0242

4a. Facility Name *(If not institution, give street end number)*: Williamsport Nursing Home

4b. City, Town, or Location of Death: Williamsport

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 236-03-0588

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthdey)*: 95 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 26, 1907

9. Birthplace *(State or Foreign Country)*: MD Samples Manor

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Smithsburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: P. O. Box 190

10f. Zip Code: 21783

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): unk — College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor

16b. Kind of Business/Industry: Army Depot

17. Father's Neme *(First, Middle, Last)*: Millard Martin Hanes

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian May Boyers

19a. Informant's Name/Relationship *(Type, Print)*: Clarence B. Haller

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: P. O. Box 190 Smithsburg MD 21783

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cumberland Valley Crematorium

Date: Nov 17

20c. Location - City or Town, State: Waynesboro PA 17268

21. Signature of Funeral Service Licensee: ▶ Jeanette M Ulmer

22. Name and Address of Facility: Grove-Bowersox Funeral Home, Inc. 50 S Broad ST Waynesboro PA 17628

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)
a. Renal failure — 1 year
Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last
b. Prostate Cancer — years
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

anemia related to renal failure

Osteoporosis with compression fractures

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Cynthia Kuttner-Sands MD

29c. License number: D47451

29d. Date signed *(Month, Day, Year)*: November 20, 2003

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Cynthia Kuttner-Sands MD. Williamsport Nursing Home 154 North Artizan Street Williamsport, Maryland

**State Registrar**

31. Dete filed *(Month, Day, Year)*: DEC 08 2003

32. Registrer's Signature: ▶ Renee D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificete hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Sylvester Reynolds Hanes 242 Am 1/16/03 SH-10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **Amend Item #10f&19b per** *Certificate of Death* FN 0827 1/5/04 tas

Reg. No. 2003 41348

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Benjamin Roy Hornbaker Jr. | 12 / 3 / 2003 | 01:33 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Union Memorial Hospital | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-26-6166 | 1☐M 2☐F | 78 Yrs. | | | Oct. 31 1925 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Pennsylvania | Franklin | Waynesboro | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15618 Marsh Road | ~~12268~~ 17268 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | Maintena nce | Maryland Ribbon |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Benjamin Roy Hornbaker | Francis Hamby |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Rachel Carleda Hornbaker/wife | 15618 Marsh Rd. Waynesboro, Pennsylvania ~~12268~~ 17268 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Smithsburg Crematory | Dec 7 2003 | Smithsburg, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Douglas A. Fiery | Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Bleeding from Thoracic Aortic Aneurysm | 2 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Leak from Endovascular Repair of thoracic | 7 days |
| | Due to (or as a consequence of): c. aortic Aneurysm | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Severe Chronic Obstructive Pulmonary Disease

Bullous Emphysema

Peripheral vascular Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Addasi, MD | AT-2438946-P41 | Dec. 3, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Al A. Addasi, MD Dept. of Surgery

Union Memorial Hospital 201 East University Pkwy. Baltimore Maryland 21218

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 08 2003 | ▶ Karen D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

54-10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item#21perFHG826 12/20/03 EW

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41349

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Robert Lee Harrison | NOVEMBER 26 2003 | 4:25 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St Mary's Hospital | Leonardtown | ST mary's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 223-18-4658 | 1☐M 2☐F | 83 Yrs. | | | 6/7/1920 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Charles | LaPlata | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12550 Charles Street | 20646 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Painter | Contractor |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Hilary Harrison | Ruth Viola Beech |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Victoria Bradhurst/Daughter | 12550 Charles Street,LaPlata,Md 20646 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Potomac Crematory | 11/29/03 | Dale City,Va |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| CC# 0420 ▶ Robert George McCollom perDVR | Cunningham Funeral Home 811 Cameron ST,Alexandria,Va 22314 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. congestive heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebrovascular accident — not known

Due to (or as a consequence of):

c. possible sepic shock

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

c dyy colin's
Gastero intestinal bleed

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Kshama Garg MD | D60826 | 11/27/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KSHAMA GARG PHILIP J BEAN BUILDING HOLLYWOOD MD 20636

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 20 2003 | ▶ |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ROBERT LEE HARRISON

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41350

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Teddy Ruth Hensley | December 16, 2003 | 05:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Citizens Nursing Home | Havre De Grace | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-38-9845 | 1☐M 2☒F | 79 Yrs. | | | October 11, 1924 | Kentucky |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Aberdeen | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1229 North Stepney Road | 21001 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | 0 | Homemaker | Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Arthur L. Walters | Vicie M. Manning |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sharon Litzinger (daughter) | 678 Lookout Road, Lashmeet, WV 24733 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | R.A. Ferris & Co. Inc. | 12/17/2003 | West Chester, PA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Kenneth B. Carey | Tarring-Cargo Funeral Home, P.A. 333 S. Parke Street, Aberdeen, MD 21078 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Cold Cerebral embolism

Due to (or as a consequence of):

c. Dementia

Due to (or as a consequence of):

d. Hypertension

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ J.T. Lee M.D. | D20661 | 12/16/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.T. Lee MD. 669 Revolution St. Havre de Grace MD 21078

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Hensley, Ruth T.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41351

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Robert | Wesley | Jacobs | Dec 17, 2003 | 7:07 am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 679 Fayette Street | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212241954 | 1 [X] M 2 [ ] F | 74 Yrs. | | | Feb 26, 1929 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Allegany | Cumberland | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 679 Fayette Street | 21502 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | clerk | Market |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Russell Irvin Jacobs | Lucy Louella Dove |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Colleen Jacobs wife | 679 Fayette Street Cumberland MD 21502 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Scarpelli Funeral Home, P.A. | 12/18/2003 | Cresaptown MD |

21. Signature of Funeral Service Licensee: James F Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Respiratory Failure | months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Severe pulmonary Emphysema | years |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) ____ 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
urinary tract infection
peripheral vascular disease

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| R. Espina, MD | D03459 | 12/17/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. ESPINA 902 Seton Drive, Cumberland, Md

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 19 2003 | Jeanne B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2003 41352

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Stanley Leroy Kretsinger,Jr.

2. Date of Death: Month December Day 4 Year 2003

3. Time of Death: 2017 PM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington County

**Funeral Director**

5. Social Security Number: 212-14-7811

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 14, 1922

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington Co.

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 326 Belview Avenue

10f. Zip Code: 21742

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No

If Yes, Give Year or Dates: 1943 to 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Production Supervisor

16b. Kind of Business/Industry: Aircraft Mfg.

17. Father's Name (First, Middle, Last): Stanley Leroy Kretsinger, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Helen Jeanette LaMar

19a. Informant's Name/Relationship (Type, Print): Shelley L. Tinney/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6112 Twain Drive New Market, MD 21774

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park

Date: 12-9-2003

20c. Location - City or Town, State: Hagerstown, MD

21. Signature of Funeral Service Licensee: Douglas A. Fiery

22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, MD 21742

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE — 2 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 15 YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23e. Did tobacco use contribute to the cause of death? 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Brull MD Personal Physician

29c. License number: D 0004359

29d. Date signed (Month, Day, Year): DEC 5 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT BRULL 1459 POTOMAC ST. HAGERSTOWN, MD 21742

**State Registrar**

31. Date filed (Month, Day, Year): DEC 08 2003

32. Registrar's Signature: Steven A. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41353

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Mary Eleanor Montgomery | December 06 2003 | 326 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington County Hospital | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-48-5150 | 1☐ M 2☒ F | 70 Yrs. | | | December 2, 1933 | Washington DC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 156 Buttercup Drive | 21740 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Senior Clerk | Metropolitan Life Insurance Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Rayner A. Montgomery, Sr. | Annie Louise Goldsmith |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Anna Leslie / Sister | 9347 Childacrest Drive, Boonsboro, MD 21713 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Rest Haven Cemetery | 12/10/03 | Hagerstown, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ MO#1326 | Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Intracerebral / Hemorrhage — Approximate Interval Between Onset and Death: 10 days

Due to (or as a consequence of):
b. Thrombocytopenia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Disseminated Intravascular coagulation

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Rheumatoid Arthritis

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | 27. Manner of Death |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) | 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined |

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Dino J. DeLaportas MD | D0026523 | December 7, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dino J. DeLaportas MD 1110 Medical Charles Road Hagerstown MD 21742

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 08 2003 | ▶ |

**State Registrar**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

64-24

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41354

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Ernest Woodrow McCoy | December 7 2003 | 4:35 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Beverly Healthcare | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-12-0301 | XX 1 M 2 F | 91 Yrs. | | | Jan. 7, 1912 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1 Yes 2 XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11400 Stonecroft Court | 21742 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 XX Widowed 4 Divorced | 1 Yes 2 XX No If Yes, Give Year or Dates: | 1 Yes 2 XX No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 3 | | Farmer | Agriculture |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Alonza Francis McCoy | Renie Virginia Marshall |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| R. Kenneth Keiper - Cousin | P.O. Box 192 Bolivar, Pennsylvania 15923 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Mt. View Cemetery | Dec. 10, 2003 | Sharpsburg, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Mark M. Osborne | Osborne Funeral Home, P.A. 21795<br>425 S. Conococheague St. Williamsport, Maryland |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. gangrene left foot - | 4 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Coronary artery disease | 3 months |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 Yes 2 No 3 Probably 4 X Unknown | 1 Yes 2 X No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 X No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 X Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

| 29a. Certifier (Check only one) | |
|---|---|
| 1 X | **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
| 2 | **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Mayer Ghaly | D28365 | 12-8-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MANZAR J SHAFI 368 mill Street Hagerstown MD 21740

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | ▶ Karen D. Spike |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#29dperPHYG826 12/20/03 EW

# Certificate of Death

Reg. No. 2003 41355

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): IVA MAE MATTHEWS

2. Date of Death: Month December Day 4, Year 2003

3. Time of Death: 3:15 AM

4a. Facility Name (If not institution, give street and number): Alice Byrd Tawes Nursing Home

4b. City, Town, or Location of Death: Crisfield

4c. County of Death: Somerset

**Funeral Director**

5. Social Security Number: 216-10-8156

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 21, 1920

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 282 Somers Cove Apartments

10f. Zip Code: 21817

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arthur T. Tyler

18. Mother's Name (First, Middle, Maiden Surname): Bertha M. Sterling

19a. Informant's Name/Relationship (Type, Print): Carolee Creasy (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8909 Arden Station Rd. - Westover, MD 21871

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Paul's Cemetery

Date: 12/7/03

20c. Location - City or Town, State: Marion Station, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw, Jr.

22. Name and Address of Facility: Bradshaw & Sons Funeral Home, 306 W. Main St. - Crisfield, MD 21817

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: V

29c. License number: D 48098

29d. Date signed (Month, Day, Year): 12/04/2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817

**State Registrar**

31. Date filed (Month, Day, Year): DEC 20 2003

32. Registrar's Signature

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

mail #29d

DHMH 16 Rev 6/95

ROBERT G. NAYLOR
DOB 3-21-36

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#3,28e,28fperMEOG826 12/20/03 EW

# Certificate of Death

Reg. No. 2003 41356

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Robert George Naylor, Sr. | December 8, 2003 | 10:01 ~~9:00~~ a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 5402 Arcadia Avenue | Upperco | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-32-7007 | 1☒ M 2☐ F | 67 Yrs. | | | Mar 24, 1936 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Upperco | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5402 Arcadia Avenue | 21155 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1955-1990 | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Master Chief Machinist | U.S. Navy |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Clyde Naylor | Grace Elizabeth Horney |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Bruce Naylor, brother | 5402 Arcadia Avenue, Upperco, MD 21155 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Carroll Cremations | 12/11/2003 | Hampstead, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Steven W Eline MD723 | Eline Funeral Home 934 South Main St, Hampstead, MD 21074 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ANOXIC BRAIN INJURY | |
| Due to (or as a consequence of): | b. ASPHYXIA | |
| Due to (or as a consequence of): | c. AIRWAY OBSTRUCTION | |
| Due to (or as a consequence of): | d. HANGING | |

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | 12·8·03 | 10:01 A M | 1☐ Yes 2☒ No | SELF HANGING |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Home | 5402 Arcadia Ave, Upperco, MD |

29a. Certifier (Check only one) 1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Francesco Grasso MD | D 38363 | 12·10·2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCESCO GRASSO MD 6569 N. CHARLES ST TOWSON

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 20 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41357

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Wayne Willard Pitts

2. Date of Death (Month, Day, Year): December 2, 2003

3. Time of Death: 0500 AM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 212-38-9167

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 19, 1939

9. Birthplace (State or Foreign Country): Wisconsin

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 11 West Baltimore Street

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel Worker

16b. Kind of Business/Industry: Steel Company

17. Father's Name (First, Middle, Last): Willard Pitts

18. Mother's Name (First, Middle, Maiden Surname): Lorraine Sperry

19a. Informant's Name/Relationship (Type, Print): Louise Yost-Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14901 Rufus Wilson Rd. Clear Spring, Maryland 21722

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity Christian Cem.

Date: Dec. 5, 2003

20c. Location - City or Town, State: Clear Spring, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Osborne Funeral Home 21795 425 S. Conococheague St. Williamsport, Maryland

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic coronary artery disease — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dino J. Delaportas MD

29c. License number: D0026523

29d. Date signed (Month, Day, Year): December 2, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dino J. Delaportas MD 11110 Medical Campus Road, Hagerstown 21742

**State Registrar**

31. Date filed (Month, Day, Year): DEC 04 2003

32. Registrar's Signature:

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

JAMES B PATTERSON
03-7664
DA?

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar: Amended #20b WCHD/SH 12/10/03 per FH

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41358

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Brian Patterson

2. Date of Death (Month, Day, Year): NOVEMBER 30, 2003

3. Time of Death: 11:40 AM

4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

**Funeral Director**

5. Social Security Number: 217-58-3867

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 38 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 19, 1965

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1307 Oak Hill Avenue

10f. Zip Code: 21742

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

16b. Kind of Business/Industry: General Manufacturing

17. Father's Name (First, Middle, Last): Raymond C. Patterson

18. Mother's Name (First, Middle, Maiden Surname): Norma J. Kinkel

19a. Informant's Name/Relationship (Type, Print): Raymond C. Patterson/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1307 Oak Hill Avenue, Hagerstown, MD. 21742

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ~~Rose Hill Cemetery~~ Rest Haven Cemetery

Date: Dec. 4, 2003

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Douglas A. Fiery

22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD. 21742

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. intraoral gunshot wound

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 11-30-03

28b. Time of Injury: Found 10:50 AM

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): at home

28f. Location - Street and Number or R.F.D. Number, City or Town, State: ~~511 North Locust Street~~ 1307 Oak Hill Ave Hagerstown MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patricia Aronica-Pollak MD

29c. License number: OCME

29d. Date signed (Month, Day, Year): DECEMBER 1, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRICIA ARONICA-POLLAK MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 08 2003

32. Registrar's Signature: Karen D. Spencer

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

54-6

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41359

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Ruth Esther Pepple | December 8 2003 | 0330 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington County Hospital | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-12-1069 | 1☐ M 2☒ F | 82 Yrs. | | | 02/05/1921 | PA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Washington | Hagerstown | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11 W. Baltimore St. | 21740 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|
| Elementary/Secondary (0-12): 8 College (1-4or 5+): | Seamstress | Clothing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Luther Calvin Woodring | Anna Elizabeth Nail |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Larry Pepple / Son | 1143 Lindsay Lane, Hagerstown, MD 21742 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Antietam Cemetery | 12/11/2003 | Waynesboro, PA |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street, Hagerstown, MD 21740

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cerebral Infarction | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Atrial Fibrillation | |
| | c. | |
| | d. | |

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D0060396 | 12/8/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FARID MURSHED 1126 Opal Court Hbg. Md. 21742

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 09 2003 | ▶ [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SA-7

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41360

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Helen Keith Rizk

2. Date of Death (Month, Day, Year): DECEMBER 07, 2003

3. Time of Death: 4:48PM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 220-54-4668

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb.20,1917

9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: Md.

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 55 E. Washington St. Apt. 215

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): William McConnell

18. Mother's Name (First, Middle, Maiden Surname): Euphemia Keith

19a. Informant's Name/Relationship (Type, Print): Douglas W. Killen (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 112 Hermit Woods Rd. Sanbornton,NH.03269

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory

Date: Dec.8,2003

20c. Location - City or Town, State: Smithsburg,Md.

21. Signature of Funeral Service Licensee: Dennis L. Davis

22. Name and Address of Facility: 12525 Bradbury Ave. Davis Funeral Home Smithsburg,Md. 21783

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Failure — Approximate Interval Between Onset and Death: 6 hours

Due to (or as a consequence of):

b. Small Bowel Obstruction — 1 week

Due to (or as a consequence of):

c. Metal Carcinoma — 2 months

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J. McCormick MD

29c. License number: D41667

29d. Date signed (Month, Day, Year): 12-8-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael McCormick 11110 Medical Campus Hagerstown MD

**State Registrar**

31. Date filed (Month, Day, Year): DEC 09 2003

32. Registrar's Signature: Sharon D. Spade

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41361

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Delmar Eugene Riffle
2. Date of Death — Month: December Day: 14 Year: 2003
3. Time of Death: 2155
4a. Facility Name (If not institution, give street end number): 2791 Francis Scott Key Highway
4b. City, Town, or Location of Death: Taneytown
4c. County of Death: Carroll County

**Funeral Director**

5. Social Security Number: 216-05-2004
6. Sex: 1☒M 2☐F
7. Age (In yrs. lest birthdey): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 28 1912
9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Carroll County
10c. City, Town or Location: Taneytown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 2791 Francis Scott Key Highway
10f. Zip Code: 21787
10g. Citizen of What Country?: United States

11. Maritel Stetus: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): owner and operator
16b. Kind of Business/Industry: vending company

17. Fether's Neme (First, Middle, Last): Albertus G. Riffle
18. Mother's Name (First, Middle, Maiden Surname): Cora M. Nelson

19a. Informant's Name/Relationship (Type, Print): Susan R. Mason / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6901 N. Gleneagles Drive Tucson, Arizona 85718

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity Lutheran Cemetery
Date: Dec 18 2003
20c. Location - City or Town, State: Taneytown, Maryland

21. Signature of Funeral Service Licensee: Alan C. Purvis
22. Name and Address of Facility: Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. CAD (CORONARY ARTERY DISEASE)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

DEMENTIA

DEPRESSION

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes cese referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): ☒1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐2 **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture end title of certifier: M.D.
29c. License number: D0054580
29d. Date signed (Month, Day, Year): 12/15/03

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Wasim Fakhar, M.D. 417-E E. Baltimore Street, Suite D Taneytown, MD 21787

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrer's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CPM
03-08027
JEREMY ROBERTSON

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41362

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jeremy Ryan Robertson
2. Date of Death (Month, Day, Year): December 13, 2003
3. Time of Death: 08:35 AM
4a. Facility Name (If not institution, give street and number): south of Klondike Rd. and Old Legislative Rd.
4b. City, Town, or Location of Death: Lothian
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 218-04-2964
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 23 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): October 04, 1980
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Lonaconing
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 17114 Jackson Run Road
10f. Zip Code: 21539
10g. Citizen of What Country?: USA
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Labor
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): Robert Joseph Robertson
18. Mother's Name (First, Middle, Maiden Surname): Deborah Kay Kyle
19a. Informant's Name/Relationship (Type, Print): Deborah Kay Diehl-Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 Charlestown St, Lonaconing, Maryland 21539
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mountain View Cemetery
Date: December 17, 2003
20c. Location - City or Town, State: Moscow Mills, Maryland
21. Signature of Funeral Service Licensee: Jan E. McKenzie
22. Name and Address of Facility: Eichhorn-McKenzie Funeral Home P.A. 8 E. Main St., Lonaconing, Md. 21539

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Gunshot wound to back of torso

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 12/13/03
28b. Time of Injury: 7:42 AM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject shot during hunting
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Field / woods
28f. Location (Street and Number or Rural Route Number, City or Town, State): Klondike Hill, Allegany, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Zabilka MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 14, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Zabilka MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003
32. Registrar's Signature: James B Sparks

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41363

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Rosalie Ella Ridenour

2. Date of Death: Month December Day 11 Year 2003

3. Time of Death: 9:05 A.M

4a. Facility Name (If not institution, give street and number): Clearview Nursing Home

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 216-68-4997

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 4, 1911

9. Birthplace (State or Foreign Country): PA

Usuef Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Big Pool

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10872 Big Pool Road

10f. Zip Code: 21711

10g. Citizen of What Country?: USA

11. Maritaf Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Isaiah Burton

18. Mother's Name (First, Middle, Meiden Surname): Catherine Bishop

19a. Informant's Name/Relationship (Type, Print): Sylvia DeShong/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 116 S.Schoolhouse Rd. Thomasville, PA 17364

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Warfordsburg Presby.

Date: 12/16/03

20c. Location - City or Town, State: Warfordsburg, PA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Grove Funeral Home, P.A. 141 West Main Street Hancock, MD 21750-0368

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. [illegible]

Due to (or as a consequence of):

Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

[illegible]

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certfier: [signature] MD

29c. License number: D1[illegible]9

29d. Date signed (Month, Day, Year): Dec 11, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VASANT DATTA MD 340 MILL ST HAGERSTOWN MD 21740

**State Registrar**

31. Date filed (Month, Day, Year): DEC 19 2003

32. Registrar's Signature: [signature]

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospitel or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41364

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| James Nathaniel SHACKELFORD | December 1, 2003 | 1030A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington County Hospital | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 233-70-9145 | 1☒M 2☐F | 56 Yrs. | | | Dec.14,1946 | West Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| W. Va. | Berkeley | Martinsburg | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 54 Beefy Lane | 25401 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: Vietnam | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | LPN | health care |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Carleton Shackelford | Edith Springer |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sandra D. Hughes - ex-wife | P. O. Box 421, Winchester, Va. 22604 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Culpeper National Cem. | 12/8/03 | Culpeper, Virginia |

21. Signature of Funeral Service Licensee: Scott M Minnich

22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure Coronary Artery Disease
Diabetes Mellitus Hypothyroidism multiple
Dementia ulcers

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [illegible] MD | D18019 | DEC. 2, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VASANT DATTA, MD 340 MILLST HAGERSTOWN MD 21740

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 04 2003 | Karen B. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41365

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: LEROY HARRY SMITH

2. Date of Death (Month, Day, Year): December 5, 2003

3. Time of Death: 0350

4a. Facility Name *(If not institution, give street and number)*: 1175 PROFESSIONAL COURT

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

**Funeral Director**

5. Social Security Number: 215-36-7242

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 27, 1910

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: HAGERSTOWN

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1175 PROFESSIONAL COURT

10f. Zip Code: 21742

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER

16b. Kind of Business/Industry: AGRICULTURAL TRUCKING

17. Father's Name *(First, Middle, Lest)*: HARRY M. SMITH

18. Mother's Name *(First, Middle, Maiden Surname)*: SADIE E. CLINE

19a. Informant's Name/Relationship *(Type, Print)*: M. CATHERINE SMITH/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 19915 JEFFERSON BLVD., HAGERSTOWN, MD 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BOONSBORO CEMETERY

Date: 12/9/03

20c. Location - City or Town, State: BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean

22. Name and Address of Facility: BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular disease — 20 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Assisted Living facility

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George Newman PH.D. MD

29c. License number: D0017591

29d. Date signed *(Month, Day, Year)*: December 5, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George C. Newman II MD 11110 Medical Campus Rd Hagerstown MD 21742

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 08 2003

32. Registrar's Signature

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41366

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Joseph Preston Shupp | December 4, 2003 | 3:30 a |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 11184 Dam 5 Road | Clear Spring, | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-14-1429 | 1 [X] M 2 [ ] F | 86 Yrs. | | | Dec. 6, 1916 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Washington | Clear Spring, | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11184 Dam 5 Road | 21722 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8th grade | 0 | Farmer | Farm |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John William Shupp | Mazie A. Moore |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| daughter Deanna Mullendore | 11228 Dam 5 Road Clear Spring, MD 21722 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) Date | 20c. Location - City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | St. Paul Cemetery Dec. 8, 2003 | Clear Spring, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Donald E. Thompson | Donald Edwin Thompson Funeral Home, Inc P.O. BOX 310 Clear Spring, MD 21722 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE MYOCARDIAL INFARCTION | SUDDEN |
| Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. ATHEROSCLEROTIC HEART DISEASE | YEARS |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

NONE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Barry Cohen, MD | D01040 | 12-04-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BARRY COHEN, MD - 322 E ANTIETAM ST, HAGERSTOWN, MD 21740

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 08 2003 | Donna D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41367

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HOWARD JASON THOMAS SR.

2. Date of Death: Month December Day 3 Year 2003

3. Time of Death: 1555 M

4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

**Funeral Director**

5. Social Security Number: 220-30-9003

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 23, 1918

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: BOONSBORO

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 19523 MILL POINT ROAD

10f. Zip Code: 21713

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FARMER

16b. Kind of Business/Industry: FARM

17. Father's Name (First, Middle, Last): JASON LESTER THOMAS

18. Mother's Name (First, Middle, Maiden Surname): NANNIE BELL COX

19a. Informant's Name/Relationship (Type, Print): HOWARD J. THOMAS JR./SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5118 RUSSETT ROAD, ROCKVILLE, MD 20853

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BOONSBORO CEMETERY

Date: 12/8/2003

20c. Location - City or Town, Stete: BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean

22. Name and Address of Facility: EAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

emphysema

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D32518

29d. Date signed (Month, Day, Year): 12/4/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Gwedenet 21 Wyand Drive Keedysville Maryland

**State Registrar**

31. Date filed (Month, Day, Year): DEC 08 2003

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Thomas Howard

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41368

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Harold Truman WELLS, Jr. | December 3, 2003 | 8:40 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 823 Chestnut Street | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 023-22-5461 | 1☒M 2☐F | 73 Yrs. | | | July 24, 1930 | New York |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 823 Chestnut Street | 21740 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: WW II | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | engineer | cranes |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harold Wells, Sr. | Ester Brooks |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Louise C. Wells - wife | 823 Chestnut St., Hagerstown, Md. 21740 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Rose Hill Cemetery | 12/6/03 | Hagerstown, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Scott M Minnich | MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer — 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Michael J. McCormack MD | D 41667 | 12-4-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael McCormack 11110 Medical Campus Hagerstown MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 05 2003 | ▶ Sharon A. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2003 41369

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| James Lester Ayres | December 17, 2003 | 5:15 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 984 Riversedge Circle | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577-01-2264 | 1 [X] M 2 [ ] F | 94 Yrs. | | | Nov. 21, 1909 | Washington, DC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Annapolis | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 984 Riversedge Circle | 21401 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Supervisor | C&P Telephone Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Ayres | Olive Carter |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dorothy A. Ayres/ Wife | 984 Riversedge Circle, Annapolis, MD 21401 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Cedar Hill Cemetery | 12-22-03 | Suitland, MD |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home, 2973 Solomons Island Rd. Edgewater, MD 21037

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. metastatic prostate carcinoma | unknown |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| tF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

alzheimers Disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D41955 | 12-18-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rebecca Elon MD 8601 Veterans Highway Millersville MD 21108

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | [signature] |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41370

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| SINCLAIR ALLEYNE | December 15 2003 | 1:15A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Manor Care Nursing Home | Laurel | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 063-30-0074 | 1☒ M 2☐ F | 87 Yrs. | | | July 30, 1916 | Barbados, W.I. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George's | Lanham | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4311 Kenmount Road | 20706 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Steam Engineer | Private |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Unobtainable | Unobtainable |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Alice Alleyne/Wife | 4311 Kenmount Road, Lanham, Maryland 20706 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Fort Lincoln Cemetery | 12/20/2003 | Brentwood, Maryland |

21. Signature of Funeral Service Licensee: ▶ Nancy A. Pancentire

22. Name and Address of Facility: FORT LINCOLN FUNERAL HOME, 3401 Bladensburg Road, Brentwood, Maryland 20722

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Arteriosclerotic Cardiovascular Disease | 3 Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Prignam Saini | D-28998 | December 19, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Prignam Saini, M.D., 9101 Cherry Lane, #211, Laurel, Maryland 20708

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41371

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Zeddie Henry Bernhardt | December 20, 2003 | 12:50am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Golden Age Guest Home | Sykesville | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-20-8239 | 1 ☐ M 2 ☐ F | 78 Yrs. | | | Jan. 5, 1925 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Carroll | Sykesville | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1499 Elm Avenue | 21784 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Draftsman | W.R. Grace/Dupont |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Bruno Henry Bernhardt | Edith Scheeler |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Arthur Haeffner (Step-son) | 5705 Carroll Dale Drive Sykesville, MD 21784 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | All County Cremation | | Sykesville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Brian C Haight | HAIGHT FUNERAL HOME CHAPEL, PA (Box 195) Sykesville, MD 21784 (410) 795-1400 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SARCOMA LEFT THIGH — > 1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Rebecca A Turner MD | D20806 | 12/22/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PATRICK TURNER - SUITE 102 / 1000 LIBERTY ROAD ELDERSBURG, MD 21784

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

**State Registrar**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41372

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Esther Brady

2. Date of Death: Month December Day 21 Year 2003

3. Time of Death: 215A M

4a. Facility Name (If not institution, give street and number): Riverview Care & Nursing Center

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-10-7291

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Yeer): Aug. 17, 1914

9. Birthplace (State or Foreign Country): Ohio

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2028 Kelmore Road

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George W. Hercules

18. Mother's Name (First, Middle, Maiden Surname): Adis Bowman

19a. Informant's Name/Relationship (Type, Print): Eleanor Bailiff / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6715 Pine Ave., Balto.,Md. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): OakLawn Cemetery

Date: 12-23-03

20c. Location - City or Town, State: Balto.,Md. 21224

21. Signature of Funeral Service Licensee: Laura Bailiff Woods

22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd. Balto.,Md. 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ASPIRATION PNEUMONIA

Due to ( ) as a consequence of):
b. MALNUTRITION

Due to (or as a consequence of):
c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):
d. DIABETES MELLITUS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) ___ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Saviuder K Tuteja MD

29c. License number: D27788

29d. Date signed (Month, Dey, Year): 12/22/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Saviuder K Tuteja 2 Market Place Dundalk MD 21222

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature:

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41373

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Warren Edgar Becker, Jr. | December 21 2003 | 6:00P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| North Arundel Hospital | Glen Burnie | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-52-1287 | 1☒M 2☐F | 54 Yrs. | | | May 22, 1949 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Glen Burnie | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 125 Glendale Avenue | 21061 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | Courier | Federal Express |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Warren Edgar Becker, Sr. | Cecelia Jo Hooper |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Karen Becker - Wife | 125 Glendale Avenue Glen Burnie, Maryland 21061 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Balt. Wash. Crematory | 12/29/03 | Laurel, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ M. Pgh | Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. LUNG CANCER | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☑No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ beleke kassahun MD | D0055973 | DECEMBER 21, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ZELEKE DESSIE 11500 SUTHERLAND HILL WAY SILVER SPRING MD 20904

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM #5&19a PER FH G827 1/20/04 JH

Reg. No. 2003 41374

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MILDRED R. BURL
2. Date of Death (Month, Day, Year): DECEMBER 21 2003
3. Time of Death: 4:40 A M
4a. Facility Name (If not institution, give street and number): Ridgeway Manor
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore Co.

**Funeral Director**

5. Social Security Number: ~~215-03-5065A~~ ~~215-03-5065~~
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 17 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 600 Light Street Apt. 301
10f. Zip Code: 21230
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Worker
16b. Kind of Business/Industry: Baltimore City Public Schools

17. Father's Name (First, Middle, Last): James G. Harrison
18. Mother's Name (First, Middle, Maiden Surname): Alice Biggs

19a. Informant's Name/Relationship (Type, Print): ~~Ellen McWilliams~~ ELLA McWILLIAMS (Niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 407 Allview Court, Catonsville, Md. 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 12/24/2003
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonitis — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypothyroidism, Hypertension, Congestive Heart failure, Diverticulosis, Polymyalgia rheumatica

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Geetha Raja MD
29c. License number: D27541
29d. Date signed (Month, Day, Year): December 22, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEETHA RAJA MD 4367 Hollins Ferry Rd, Baltimore, MD-21227

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41375

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Vernon | | Boyd | December 18 2003 | 9:47A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-56-5843 | 1☑M 2☐F | 52 Yrs. | | | APRIL 13, 1951 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | BALTIMORE | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2742 MURA STREET | 21213 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | TRUCK DRIVER | TRANSPORTATION |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| SAMUEL LEE BOYD | SARAH DRUMMOND |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| AUDRY Y. BOYD / WIFE | 2742 MURA STREET BALTIMORE, MD 21213 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | KING MEMORIAL PARK | 12-27-03 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Vaughn Greene | VAUGHN C. GREENE FUNERAL HOME 4905 YORK ROAD BALTIMORE, MARYLAND 21212 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. acute myocardial infarction — Approximate Interval Between Onset and Death: 2 days

Due to (or as a consequence of):
b. coronary artery disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

acute promyelocytic leukemia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD PhD | RES-000 | December 18, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSEPH DEDRICK JORDAN, MD, PHD JOHNS HOPKINS HOSPITAL TOWER 11D DOCTORS LOUNGE 600 NORTH WOLFE STREET BALTIMORE MD 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41376

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| EUGENE BAILEY | DECEMBER 18TH 2003 | 16:10 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| UPPER CHESAPEAKE MEDICAL CENTER | BELAIR | HARFORD CO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 249-24-3048 | 1☒M 2☐F | 89 Yrs. | | | AUG 20 1914 | SOUTH CAROLINA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | HARFORD CO | FALLSTON | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2105 PARSONAGE LN | 21047 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 5th grade | | CEMENT FINISHER | CONSTRUCTION |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| NORMAN BAILEY | BERTHA COE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Norman Bailey/Son | 15 Splitleaf Ct., Savarat GA., 31419 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | HIGHVIEW MEMORIAL | 12-22-03 | FALLSTON, MARYLAND |

21. Signature of Funeral Service Licensee ▶ Charles H Powell

22. Name and Address of Facility: WM C BROWN COMMUNITY FUNERAL HOME-HARFORD P.A. 321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 16 DAYS

Immediate Cause (Final disease or condition resulting in death): a. ASPIRATION PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MALNUTRITION

SELLAR BRAIN TUMOR.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M.D. | D 21207 | DECEMBER 19TH 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANZ C. VELLA-CAMILLERI MD 5 MIDCREST COURT BALTIMORE MD 21286

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1520 12/18/03 3233712 EUGENE BAILEY

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41377

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): SEAN McCARTHY-BOLLARD

2. Date of Death: Month December Day 15 Year 2003

3. Time of Death: 3:40pm M

4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: None

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday) Yrs.: If Under 1 Year Months / Days; If Under 24 Hrs. Hours 1 / Min. 19

8. Date of Birth (Month, Day, Year): December 15, 2003

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8107 Dalesford Road

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Infant

16b. Kind of Business/Industry: Infant

17. Father's Name (First, Middle, Last): Paul C. Ballard

18. Mother's Name (First, Middle, Maiden Surname): Maire E. McCarthy Ballard

19a. Informant's Name/Relationship (Type, Print): NIKKI CHILCOAT GBMC PATHOLOGY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6701 N. Charles Street Towson, MD 21204

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GREENMOUNT CREMATORY

Date: 12/18/2003

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: R.A. Monaco

22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 16924 YORK RD - MONKTON, MD 21111

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lethal chromosomal anomalies (Trisomy 18) — Approximate Interval: 1 hr 19 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen Liverman

29c. License number: D36680

29d. Date signed (Month, Day, Year): 12/15/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Liverman 10 Flintlock Ct., Perry Hall, MD 21128

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature: James B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

McCarthy-Ballard, Sean
Baltimore, Maryland 21215-0036

McCarthy-Ballard, Boy
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41378

**Physician /Medical Examiner**

**Funeral Director**

1. Decedent's Name (First, Middle, Last): CHARLOTTE PERRY BARNES
2. Dete of Deeth: Month DECEMBER Day 19 Year 2003
3. Time of Death: 2247 hrs.
4a. Facility Neme (If not institution, give street end number): STELLA MARIS HOSPICE AT MERCY
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Death: N/A
5. Social Security Number: 220-18-3550
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): MAY 11, 1920
9. Birthplace (State or Foreign Country): S. CAROLINA

Usuel Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Locetion: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street end Number: 3106 WALBROOK AVENUE
10f. Zip Code: 21216
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 6 / College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): JOHN PERRY
18. Mother's Name (First, Middle, Maiden Surname): JUNE BOULWARE

19a. Informant's Name/Relationship (Type, Print): D'VERE HOLLIS
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 4908 CHARGROVE AVE. BALTO. MD. 21215

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEM. Date: 12/27/03
20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Blenda Adams Jones
22. Name and Address of Facility: MARSHALL W. JONES, JR. FUNERAL SERVICE 1814 N. BROADWAY BALTO. MD. 21213

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): e. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one)
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify): Hospice

27. Manner of Deeth: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier:
29c. License number: D40854
29d. Date signed (Month, Dey, Year): 12/14/2003

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): DAVID RISEBERG 301 ST. PAUL PL BALTO. MD 21202

**State Registrar**

31. Dete filed (Month, Day, Year): DEC 23 2003
32. Registrer's Signeture:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pega 2 should be detached for usa as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

03-08158
Thomas Brown
RJD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41379

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Thomas Frank Brown | December 18, 2003 | 1755P. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 5205 Cobbler Court | White Marsh | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-50-2096 | 1☒M 2☐F | 55 Yrs. | | | Aug. 10, 1948 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Perry Hall | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5205 Cobbler Court | 21128 | U.S.A. |

| 11. Maritat Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1970-1972 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Firefighter | Baltimore County |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frank Brown | Lillian Nowowovski |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Charlene Brown (wife) | 5205 Cobbler Court, Perry Hall, MD 21128 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Dulaney Valley Mem'l | 12/22/2003 | Timonium, Maryland |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Schimunek Funeral Homes, 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Dey, Year): December 19, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JULIAN LOCKE MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature: [signature]

ORIGINAL

DHMH 17 Rev 1/2001

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HUGHIE EDWARD BOWMAN, JR.
UNK 03-399
03-08160
RPD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41380

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Hughie E. Bowman JR.
2. Date of Death: Month December Day 18 Year 2003
3. Time of Death: 0819 P M
4a. Facility Name (If not institution, give street and number): University Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-90-0051
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 26 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 30, 1977
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 4913 Frederick Ave.
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Keeper
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Hughie E. Bowman
18. Mother's Name (First, Middle, Maiden Surname): Wanda Coombs

19a. Informant's Name/Relationship (Type, Print): Lenore Coombs - grandmother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 149 N. Denison St. Balto, MD 21229

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery
Date: 12-24-03
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Gary P. March
22. Name and Address of Facility: Gary P. March F|H 370 Fredhilton Pass Balto. MD 21229

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple gunshot wounds

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year): 12-18-03
28b. Time of Injury: 7:44 P M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: subject was shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): street
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3400 block of Elgin Ave Baltimore MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Liq Li. M.D
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 19, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LING LI. M.D 111 Penn Street, Baltimore, Maryland 21201

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41381

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): GRACE KATHERINE BRANDNER
2. Dete of Deeth: Month DEC. Day 21 Year 2003
3. Time of Death: 4:45AM
4a Fecility Name (If not institution, give street end number): FRANKLINWOODS NURSING HOME
4b. City, Town, or Locetion of Deeth: ROSSVILLE
4c. County of Deeth: BALTIMORE

**Funeral Director**

5. Social Security Number: 212-10-5186
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthdey): 85 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Aug. 3, 1918
9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 4518 Forestview Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 5 yrs. | College (1-4or 5+): N/A
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Housekeeping-Own Home

17. Fether's Neme (First, Middle, Lest): Charles Birmingham
18. Mother's Name (First, Middle, Maiden Surname): Pearl Klingenstein

19a. Informant's Name/Reletionship (Type, Print): Louis F. Brandner (Son)
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 73 Neptune Drive Joppatowne, Md. 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Holly Hill Mem. Gardens — Date: 12-23-03
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: E. J. Lassahn
22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Renal failure

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b. Allergic interstitial nephritis

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
S/p sigmoidectomy and colostomy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: Tom Edmondson MD
29c. License number: D45766
29d. Date signed (Month, Day, Yeer): December 22, 2003

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Tom Edmondson, MD 9105 Franklin Square Dr., Ste. 312, Baltimore, MD 21237

**State Registrar**

31. Dete filed (Month, Day, Yeer): DEC 23 2003
32. Registrar's Signature:

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pagas 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiana.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: Tha law raquiras that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has bean signed by tha attending physician and completely filled in by tha funeral diractor, page 2 should be detached for usa as tha burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Items 25,27,28a-fper ME.,G827-01/27/04dlb **Certificate of Death** Reg. No. 2003 41382

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Ethel S. Black | DECEMBER 21, 2003 | 4:10 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Saint Joseph Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-10-6064 | 1☐ M 2☒ F | 83 Yrs. | | | Feb. 10, 1920 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Timonium | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2525 Pot Spring Road # L309 | 21093 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | N/A | Secretary | Board of Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Mike Snoskey | Nellie Lloyd |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Robert Black/Son | 801 Gabriel Ct. #318 Frederick, MD 21702 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Dulaney Valley Memorial Gardens | December 23, 2003 | Timonium, MD |

21. Signature of Funeral Service Licensee: Michael J. Flagle

22. Name and Address of Facility: Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE

Due to (or as a consequence of):
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

CERTIFICATION APPROVED BY MEDICAL EXAMINER

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HIP FRACTURE

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | December 8,2003 | Unknown M | 1☐ Yes 2☒ No | Subject fell |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Residence | Timonium,MD 2300 Dulaney Valley Rd, # 150, |

29a. Certifier (Check only one)
☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D 30263 | 12-21-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

ORIGINAL

DHMH 17 Rev 1/2001

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41383

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EDWARD. BROWN
2. Date of Death Month Day Year: DECEMBER 21 2003
3. Time of Death: 2:25P M
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-07-3366
6. Sex: ☒ M ☐ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 26, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 56 Avalon Ave.
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1944-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8 Years
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Manufacturing
16b. Kind of Business/Industry: Esskay

17. Father's Name (First, Middle, Last): Edward Hershey Brown
18. Mother's Name (First, Middle, Maiden Surname): Elsie Pauline Young

19a. Informant's Name/Relationship (Type, Print): Linda Simpson (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 52 Yorkway Dundalk, Maryland 21222

20a. Method of Disposition: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 12/24/2003
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service License: ▶ [signature]
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — 1 WEEK
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. PNEUMONIA — 1 WEEK
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
STROKE, ATRIAL FIBRILLATION

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MEDICAL RESIDENT
29c. License number: 220 10
29d. Date signed (Month, Day, Year): DEC 21 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. MA, MD JOHNS HOPKINS BAYVIEW MEDICAL CENTER

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature: ▶ [signature]

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be completed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Davey Brown
03-08158
RJD

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM 23a&27 PER ME J827 1/06/03 JH

# Certificate of Death

Reg. No. 2003 41384

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DAVEY BRYAN BROWN
2. Date of Death (Month, Day, Year): December 18, 2003
3. Time of Death: 1745P. M
4a. Facility Name (If not institution, give street and number): Doctor's Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince Georges

**Funeral Director**

2848

5. Social Security Number: 241-04-4604
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 49 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 24, 1954
9. Birthplace (State or Foreign Country): Cove City, N.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: New Carrollton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7304 Longbranch Drive
10f. Zip Code: 20784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Clinton Oates
18. Mother's Name (First, Middle, Maiden Surname): Mattie Brown

19a. Informant's Name/Relationship (Type, Print): Patricia D. Mewborn/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7304 Longbranch Drive, New Carrollton, MD 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: 12/26/2003
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Nancy A. Perentis
22. Name and Address of Facility: FORT LINCOLN FUNERAL HOME, 3401 Bladensburg Road, Brentwood, Maryland 20722

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. PROBABLE SEPSIS DUE TO SMALL BOWEL NECROSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check on one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 19, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41385

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edward Bell

2. Date of Death: Month 12 Day 20 Year 03

3. Time of Death: 10:09 AM

4a. Facility Name (If not institution, give street and number): St Agnes Healthcare

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: 215-10-5287

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 23, 1916

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 9 Wade Avenue

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Louis Bell

18. Mother's Name (First, Middle, Maiden Surname): Margaret Riley

19a. Informant's Name/Relationship (Type, Print): Ruth E. Bell (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 Wade Avenue Catonsville, MD 21228

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 12-23, 2003

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John Downs

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc, 1630 Edmondson Avenue Catonsville, Maryland 21228

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — 4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P 15631

29d. Date signed (Month, Day, Year): December 20, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth Khandagle St Agnes Hospital 900 Caton Avenue Baltimore, Maryland 21229

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature:

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or if item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BELL, EDWARD

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item#23aptIIPERPHYG826 12/23/03 EW

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41386

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Winnie Leona Bloyd
2. Date of Death (Month, Day, Year): December 12 2003
3. Time of Death: 0705 M
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 462-03-8798
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 7, 1913
9. Birthplace (State or Foreign Country): Texas

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Street
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 46 Davis Road
10f. Zip Code: 21154
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Willie Henry Ely
18. Mother's Name (First, Middle, Maiden Surname): Lottie Pearl Arledge

19a. Informant's Name/Relationship (Type, Print): Steven W. Bloyd/Grandson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 46 Davis Road, Street, MD 21154

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gaines Co. Mem. Cem.
Date: 12-15-03
20c. Location - City or Town, State: Seminole, Texas

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Bilateral Pneumonia | five days |
| Due to (or as a consequence of): b. | Acute Renal Failure | two days |
| Due to (or as a consequence of): c. | Urinary Tract Infection | five days |
| Due to (or as a consequence of): d. | | |

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery disease
~~Dysphagia with chronic Aspiration~~
DISPHAGIA WITH CHRONIC TERMINAL ASPIRATION

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: George Pyrgos GEORGE PYRGOS
29c. License number: RES-000
29d. Date signed (Month, Day, Year): DECEMBER 12, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George Pyrgos MD 4940 Eastern Avenue, Baltimore, MD 21224

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar: Amend Item #8&10f per IR G826 12/23/03 tas

Reg. No. 2003 41387

Patient known as: Harry Berlin

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| HARRY | BERLIN | December 19 2003 | 1217 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-03-7156 | 1☐M 2☒F | 89 Yrs. | | | ~~11/12/14~~ NOV.11,1914 | MD. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3041 FALSTAFF ROAD APT. 503-D | ~~21215~~ 21209 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: WW II | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | SALESMAN | LIQUOR |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| ISAAC BERLIN | MOLLIE FRANK |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. RITA BERLIN/WIFE | 3041 FALLSTAFF ROAD APT.503-D BALTIMORE, MD.21209 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | (ANSHE EMUNAH) AITZ CHAIM CONGREGATION | 12/21/2003 | BALTIMORE, MD. |

21. Signature of Funeral Service Licensee: ▶ Edmund C. Rink

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE,MD.21208

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | 1 month |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure

Respiratory failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ David J. Hernandez MD | RES-000 | December 19, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David J. Hernandez, MD Sinai Hospital of Baltimore

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41388

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Walter Gordon Craig | Dec. 21, 2003 | 10:30a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Westminster Nursing & Conv. Center | Westminster | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-09-5580 | 1 X M 2 ☐ F | 92 Yrs. | | | Jan. 14, 1911 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Baltimore | Owings Mills | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4730 Atrium Court Unit 275 | 21117 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | Salesman | Creamery |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Cyrus King Craig | Norma Crisswell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Doris A. Landsman - Daughter | 408 Dove Lane, Hampstead, Md. 21074 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Lorraine Park Cem. | Dec. 24, 2003 | Woodlawn, Md. |

21. Signature of Funeral Service Licensee: ▶ H. Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. 21117

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CVA | 10 mos |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. ASCVD Due to (or as a consequence of): | 25 yrs |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 X No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 X No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ John W. Middleton | D25443 | 12/22/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton MD 688 Poole Rd. Westminster, MD 21157

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | Penny B. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41389

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Ida C. Crouse | December 18, 2003 | 10:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 61 Gambrills Road | Severn | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-14-5735 | 1☐ M 2☒ F | 94 Yrs. | | | 11-8-1909 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Severn | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 61 Gambrills Road | 21144 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Supervisor | Manufacturing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William T. Crouse | Annie H. Hopf |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Thelma Frantom (Sister) | 61 Gambrills Road Severn, Maryland 21144 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Baldwin Mem. Ch. Cem. | December 22, 2003 | Millersville, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Kirkley-Ruddick Funeral Home P.A. 421 Crain Highway Glen Burnie, Maryland 21061

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — SUDDEN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE — 9 YEARS
Due to (or as a consequence of):
c. ESSENTIAL HYPERTENSION — 20 YEARS
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Madicel Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature] M.D

29c. License number D 14160

29d. Date signed (Month, Day, Year) DECEMBER 19, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HARJIT SINGH, M.D., 5410-A RITCHIE HWY., BROOKLYN PARK, MD 21225

**State Registrar**

31. Date filed (Month, Day, Year) DEC 23 2003

32. Registrar's Signature ▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attanding Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item 18 per FH,G82903/16/04dhb

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41390

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Audrey Elaine Cunningham - Lambden | December 19, 2003 | 1:58 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 6110 Sunny Lane | Gwynn Oak | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-26-5393 | 1 ☐ M 2 ☒ F | 72 Yrs. | | | July 25, 1931 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Gwynn Oak | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6110 Sunny Lane | 21207-5238 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Telephone Operator | C & P Telephone Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph Roland Ward | Virginia Bertha Hayes ~~Bertha Virginia Mays~~ |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joseph Frederick Lambden (Husband) | 6110 Sunny Lane, Gwynn Oak, MD 21207-5238 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Lorraine Park Cemetery | Dec. 23, 2003 | Woodlawn, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Joseph J Kelbaugh M00833 | Loring Byers Funeral Directors, Inc 8728Liberty Road Randallstown, MD 21133-4784 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PANCREAS CANCER | 9months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check on one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and Title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ EW Cole MD | D16354 | 12/22/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
EW COLE STAGNES 900 CATON AVE BALT MD 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41391

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Mary M. Courtney | December 18, 2003 | 4:08A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Long View Nursing Home | Manchester | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-05-2789 | 1☐M 2☒F | 83 Yrs. | | | Oct 18, 1920 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Sparks | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 16604 Dubbs Road | 21152 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | n/a | Purchaser | Defense Contracts |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harry V. Miller | E. Grace Gorsuch |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Barbara Franklin/Niece | 16604 Dubbs Road, Spraks, Maryland 21152 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Dulaney Valley Mem. Gardens | 12/20/04 | Timonium, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael J Flagle | Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Parkinson's Disease — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia, Chiefly From Parkinsons

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

25. Was case referred to medical examiner? 1☐Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D33165 | 12/19/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Steven Schaffer, M.D. 2111 Hanover Pike Hampstead, MD 21074

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41392

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Santos Cromwell

2. Date of Death (Month, Day, Year): December 19, 2003

3. Time of Death: 1135 AM

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 565-24-5667

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 1, 1923

9. Birthplace (State or Foreign Country): Arizona

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ 1 Yes 2☐ No

10e. Street and Number: 1315 W. 37th Street

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ 1 Yes 2☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Gorgona Holquin

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Joan W. Leyrer Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1315 W. 37th Street Baltimore, Maryland 21211

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore-Washington Crematory

Date: 12/23/03

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Troy A. Carpenter

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident (Stroke) — 11 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: AT2438946

29d. Date signed (Month, Day, Year): December 20, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Decker Union Memorial Hospital 201 E. University Pkwy Baltimore MD 21218

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

03-7978
B.K.S
DONALD CONWAY

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41393

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DONALD FRANCIS CONWAY
2. Date of Death (Month, Day, Year): DEC. 11, 2003
3. Time of Death: 0900 A M
4a. Facility Name (If not institution, give street and number): 2436 NORTH CALVERT STREET
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-70-3373
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 46 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-13-57
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 120 N. KENWOOD AVE.
10f. Zip Code: 21224
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ROOFER
16b. Kind of Business/Industry: WALLACE/GALE ROOFING CO.

17. Father's Name (First, Middle, Last): DONALD CONWAY
18. Mother's Name (First, Middle, Maiden Surname): CONSTANCE GREEN

19a. Informant's Name/Relationship (Type, Print): ROBIN BEACH (COUSIN)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 120 N. KENWOOD AVE. BALTO. MD. 21224

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION
Date: 12-22-03
20c. Location - City or Town, State: BALTIMORE MD.
21. Signature of Funeral Service License: Cynthia P. Balmore
22. Name and Address of Facility: JOSEPH C. WOOD SR. F. HOME 1302 N. CENTRAL AVE. BALTO. MD. 21202

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): DEC. 12, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41394

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James L. Christie
2. Date of Death (Month, Day, Year): December 18, 2003
3. Time of Death: 7 pm M
4a. Facility Name (If not institution, give street and number): 7643 O'Daniel Court
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 219-38-9899
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jul 21, 1942
9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1 ☐ Yes 2 ☑ No
10e. Street and Number: 7643 O'Daniel Court
10f. Zip Code: 21061
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Sheet Metal

17. Father's Name (First, Middle, Last): Charles Basal Christie
18. Mother's Name (First, Middle, Maiden Surname): Catherine Ann Birtch

19a. Informant's Name/Relationship (Type, Print): Charles Robert Christie/Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 528 Orkney Road, Baltimore, MD 21212

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: Dec 22 2003
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen D. Hohmann M00382
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Cerebral vascular accident — Approximate Interval Between Onset and Death: one hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypercholesteralemia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D52583
29d. Date signed (Month, Day, Year): December 19, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Naiman, MD 5601 Loch Raven Blvd. Baltimore MD 21239

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

James Christie 12/18/03 @ 6 pm

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41395

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Milton Ronald Creswell | DECEMBER 19, 2003 | 6:15 pm M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GREATER BALTIMORE MEDICAL CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-22-2996 | 1 ☒ M 2 ☐ F | 75 Yrs. | | | Feb. 29, 1928 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Towson | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1 Flordia Road | 21204 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Korean | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Owner / Operator | Oil Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Milton Brown Creswell | Ruth Anna Wiggers |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Eunice C. Creswell / Wife | 1 Flordia Rd., Towson, Maryland 21204 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Mountain Christian Cem. | 12-24-03 | Joppa, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Stephen A. Hough | McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Non Hodgkins Lymphoma | 10 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Madhu Chaudhry MD | D41406 | DEC 20th 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madhu Chaudhry 6569 NORTH CHARLES STREET SUIR 205 Baltimore MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Creswell, Milton R.

DHMH 17 Rev 1/2001

ORIGINAL

03-8169
B.K.S
STEVEN J. CAPLAN

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

Amend Item #23pt.II per ME G830 4/19/04 tas
1- For State Registrar UNPEND ITEM 23a,27&28a-f PER ME G827 1/07/04 Th

# State of Maryland / Department of Health and Mental Hygiene
# Certificate of Death

2003 41396
Reg. No.

Physician /Medical Examiner

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| STEVEN | CAPLAN | DEC. 19, 2003 | 1205 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3215 Kenyon AVENUE | BALTIMORE CITY | N/A |

Funeral Director

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-82-0955 | 1 X M 2 F | 41 Yrs. | | | FEB 6 1962 | MD. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | X 1 Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3215 KENYON AVENUE | 21213 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | LANDSCAPER | LANDSCAPING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| DONALD CAPLAN | JOAN KRAMER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MR. DONALD CAPLAN/FATHER | 7507 LABYRINTH ROAD BALTIMORE, MD. 21208 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | BETH TFILOH CONG. | 12/21/2003 | WOODLAWN,MD. |

21. Signature of Funeral Service Licensee: Edward C. Rust

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD.21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. NARCOTIC INTOXICATION | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Medical History Of Tuberculosis Of The Spine

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 No | 1 X Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 X Other (Specify) AT SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 XX Could not be determined | found 12/19/03 | found 6:40a M | 1 Yes 2 XX No | UNKNOWN |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| FOUND AT HOME | 3215 KENYON AVE. BALTO,MD |

29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Marjorie McGrath MD | O.C.M.E | DEC. 20, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARJORIE A. KOREN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | Steven M. Spencer |

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

2849

3 OK pages

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41397

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| HOWARD | SPENCER | DOAK, SR. | DECEMBER 23 2003 | 4:45 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 755 201 STREET | PASADENA | ANNE ARUNDEL CO. |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 185-10-3820 | 1☑M 2☐F | 85 Yrs. | | | June 22,1918 | Pennsylvania |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Virginia | Lancaster | Morattico | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| P.O. Box 14 | 22523 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☑Widowed 4☐Divorced | 1☑Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | Steelworker | Steel Industry |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Anthony Doak | Mary Horner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Howard Spencer Doak Jr. (Son) | 755 201 Street, Pasadena, Maryland 21122 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory, or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Bethel United Church Methodist Cem. | 12-27-03 | Lively Virginia |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Colon Cancer | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☑Other (Specify) son's home |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| ☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | 031557 | December 23 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Russell A. DeLucy, MD. 305 Hospital Drive, Glen Burnie, Md. 21061

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1071

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41398

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Marilyn Dinsmore | December 19, 2003 | 3:30A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Casey House | Rockville | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 022-14-6266 | 1☐ M 2☒ F | 82 Yrs. | | | Oct.16,1921 | Massachusetts |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Silver Spring | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 14517 Elmhan Court | 20906 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Homemaker | Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| (unk) | (unk) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Earl I. Dinsmore | 14517 Elmhan Court; Silver Spring, MD 20906 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Loudon Park Crematory | 12/23/2003 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, MD 20852 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D0041218 | 12/10/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Harrison, MD 6001 Muncaster Mill Road; Rockville, MD 20855

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | [signature] |

ORIGINAL

DHMH 17 Rev 1/2001

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41399

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| LUCILLE HAVEN DEHUFF | 12/13/2003 | 2:40 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| WILSON HEALTH CARE | GAITHERSBURG | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-03-3087 | 1☐M 2☒F | 95 Yrs. | | | 01/24/1908 | MASSACHUSETTS |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | MONGOMERY | GAITHERSBURG | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 301 RUSSELL AVENUE | 20877 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| UNKNOWN | | SECRETARY | SECRETARIAL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| ARTHUR ROCKWOOD HAVEN | MAY DUNN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOHN C. NEU attorney/friend | 250 PROVIDENCE RD. ANNAPOLIS, MD 21401 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | LORRAINE PARK CEM. | 12/19/2003 | WOODLAWN,MD. |

21. Signature of Funeral Service Licensee ▶ RAMONACO

22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD. MONKTON, MD 21111

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. clostridium colitis | 1 month |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): colon cancer | 1 month |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

acute renal failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) — Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ John E Melnick MD | D19291 | December 14, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Melnick 911 Russell Ave. Gaithersburg, Md. 20879

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41400

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Mary Cecilia Dyson | December 21, 2003 | 8:35 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 110 Rochester Place | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-26-7754 | 1☐M 2☒F | 74 Yrs. | | | April 27,1929 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore City | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 110 Rochester Place | 21224 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 Years | | Operator | C & P Telephone Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Paul Yaren | Anna Gramanski |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Michael A. Dyson (Son) | 110 Rochester Place Baltimore, Maryland 21224 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Hilltop Service Corp. | 12/29/2003 | Towson, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cirrhosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Hepatitis B

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Breast Cancer

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) — Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D 24276 | 12.22.03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2501 [illegible] St Baltimore MD 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41401

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Francis Alton Day | December 21, 2003 | 7:24 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Laurel Regional Hospital | Laurel | Prince George |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578-44-3151 | 1☒M 2☐F | 67 Yrs. | | | Oct 07, 1936 | Washington, DC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Laurel | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3343 Valley Lee South | 20724 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Mailer | Daily newspaper |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Clarence Alton Day | Ruth Schrider |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Rose E. Day / spouse | 3343 Valley Lee South, Laurel, Maryland 20724 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | W. Arundel Crematory | Dec 27, 03 | Odenton, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ M00773 | Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes mellitus

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No |
|---|---|

| 25. Was case referred to medical examiner? 1☐Yes 2☒No | 26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |
|---|---|

| 27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D19220 | Dec. 22, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. A. Meade, M.D. 9811 Mallard Drive, #205 Laurel, Maryland 20708

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41402

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Melissa Dean | December 19, 2003 | 4:00 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 510 Central Avenue | Glen Burnie | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-58-4267 | 1☐M 2☒F | 52 Yrs. | | | May 26, 1951 | NY |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Glen Burnie | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 510 Central Ave. | 21061 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | GS 13 | United States Army |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Robert Dean | Jeanne Daley |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Jon Lauer / husband | 510 Central Ave, Glen Burnie, MD 21061 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Cremation | Dec 21 2003 | Stevensville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] M01364 | Singleton Funeral Home 1 Second Ave SW, Glen Burnie, MD 21061 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-t show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Breast Cancer | 1 year |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] M.D | D39505 | December 22, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Yudhish Markan 305 Hospital Dr. Glen Burnie, MD. 21061

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41403

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Carey | Edward | Dodd | December 13, 2003 | 4:45 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1822 Fairview Avenue | Halethorpe | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-36-4938 | 1☐ M 2☒ F | 63 Yrs. | | | July 25, 1940 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Halethorpe | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1822 Fairview Avenue | 21227 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Year or Dates: National Guard | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Supervisor | Printing Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Carey Augustine Dodd | Myrtle Marie Gilbert |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Theresa F. Choyce (Friend) | 1822 Fairview Ave., Halethorpe, MD 21227 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Loudon Park Cemetery | 12/17/03 | Baltimore, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Loudon Park Funeral Home
3620 Wilkens Ave., Baltimore, MD 21229

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic lung Ca — 8 mos

Due to (or as a consequence of):
b. COPD — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. [illegible]

Due to (or as a consequence of):
d. [illegible]

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] M.D. | D54413 | 12/16/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Young Lee 3001 S. Hanover St. Baltimore MD 21225

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41404

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| REGINA | DUNDON | DECEMBER 15 2003 | 9.30A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HARBOR HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216 30 5883 | 1☐ M 2☒ F | 69 Yrs. | | | Dec. 13, 1934 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Baltimore | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4905 Kramme Avenue | 21225 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Dundon | Angela Klosterman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard Devilbiss | 4905 Kramme Avenue Baltimore, Maryland 21225 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Bayview Crematory | 12/18/2003 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Sharron Liggett | George J. Gonce Funeral Home, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PNEUMONIA | ONE MONTH. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. COPD | |
| | Due to (or as a consequence of): c. LUNG CANCER | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☑ No 9☐ Unknown | 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☑ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ G Georgescu M.D. | RES 000 | DECEMBER 15, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GEORGIANNA GEORGESCU, 3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41405

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Maurice Leonard Elliott | December 21, 2003 | 3:20A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Greater Baltimore Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-05-7203 | 1☒M 2☐F | 88 Yrs. | | | April 19, 1915 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Sparks | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 15815 Falls Road | 21152 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates 42'-46' | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Attorney | Law |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Percey L. Elliott | Catherine Leonard |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Doris T. Elliott/Wife | 15815 Falls Road Sparks, MD 21152 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory, or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Grace United Methodist Cemetery | December 24, 2003 | Lutherville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael J. Flagle | Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | ~2 hrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Atherosclerotic Coronary Artery Disease | ~8 yrs. |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Mark M. Applefeld, M.D. | D02512 | 12/21/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Mark Applefeld, M.D. 301 St. Paul Place, Burk 310 Baltimore, MD 21202

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10f1

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41406

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Eva Elizabeth Ehrhardt

2. Date of Death — Month: December Day: 20 Year: 2003

3. Time of Death: 5:20 AM

4a. Facility Name *(If not institution, give street and number)*: 2732 Baldwin Mill Road

4b. City, Town, or Location of Death: Baldwin

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 218-90- 9602

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jun. 14, 1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Baldwin

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2732 Baldwin Mill Road

10f. Zip Code: 21013

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Gilbert George James

18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Edith Yetton

19a. Informant's Name/Relationship *(Type, Print)*: Shirley E. Hornbarger / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2732 Baldwin Mill Rd., Baldwin, Maryland 21013

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Moreland Memorial Park

Date: 12-24-03

20c. Location - City or Town, State: Baldwin, Maryland

21. Signature of Funeral Service Licensee: Kelly McComas Remyte

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21014

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

**Important: If Item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

a. Congestive Heart Failure — 5 x months

Due to (or as a consequence of):

b. Aortic Stenosis — Five years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kevin R Snyder MD

29c. License number: D33642

29d. Date signed *(Month, Day, Year)*: December 22, 2003

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Kevin C Snyder MD 754 Rockoy Avenue Bel Air MD 21014

**State Registrar**

31. Date filed *(Month, Dey, Year)*: DEC 23 2003

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41407

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Rose M. Eades | December 20 2003 | 10:20 A.M |

| 4e. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217 09 2737 | 1☐ M 2☒ F | 91 Yrs. | | | Sept. 14, 1912 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Queen Annes | Stevensville | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 202 Alleghaney Road | 21666 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8th | | Packer | McCormicks |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frank Kolodziejski | Josephine Budna |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Clara Raska / Daughter | 202 Alleghaney Road Stevensville, Maryland 21666 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Holy Cross Cemetery | 12/23/2003 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Jerome Gonce | George J. Gonce Funeral Home, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 7 8 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Cardiomyopathy | years |
| | c. Due to (or as a consequence of): Chronic obstructive pulmonary disease | years |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☒ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Urinary tract Infection

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death Check on one — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MJM MD | D0051437 | 12/20/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OKEOWO DARLY IBITOYE AAMC ANNAPOLIS MD 21401

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Joseph McDonald Fields
unknown 03-393
03-8047

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41408

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JOSEPH M. FIELDS | December 14 2003 | 1248 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Bon Secours Hospital | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213.36.2962 | 1 ☑ M 2 ☐ F | 63 Yrs. | | | 9.13.1940 | NORTH CAROLINA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | BALTIMORE | 1 ☑ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 910 N. CARROLLTON AVE. | 21217 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced | 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☑ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | LABORER | CONSTRUCTION |
| 11th | | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOSEPH C. FIELDS | LUCY HIGGS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| VERNETHA M. FIELDS / DAUGHTER | 2680 PINEWOOD DRIVE. WALDORF, MD 20601 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | KING MEMORIAL PARK | 12.22.03 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Vaughn Greene | VAUGHN C. GREENE FUNERAL HOME 4905 YORK ROAD BALTIMORE, MARYLAND 21212 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Left Ventricular Hypertrophy Complicated By Hypertherapia Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☒ Yes 2 ☐ No | 1 ☒ Yes 2 ☐ No |

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | Found 12/14/03 | Found 10:50 AM | 1 ☐ Yes 2 ☒ No | subject exposed to the cold environment |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| yard | 907 North Copy Street, Baltimore, Maryland |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Theodore M. King MD | OCME | December 15 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41409

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| OLGA | FELTON | 12 / 19 / 03 | 0702 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| UNIVERSITY OF MARYLAND | BALTIMORE | CITY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-80-2878 | 1 ☐ M 2 ☒ F | 42 Yrs. | | | OCT 21 1961 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE | 1 ☒ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3415 W. GWYNN FALLS PKWY APT 6 | 21216 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | 2yrs | OFFICE WORKER | STATE OF MARYLAND |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CHARLES H FELTON | DOROTHY M FELTON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dorothy M Felton/Mother | 3415 W. Gwynns Falls Pkwy 6A, Baltimore, Md., 21216 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 12/27/02 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Charles H Powell | WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. DISSEMINATED INTRAVASCULAR COAGULATION | |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. SEPSIS | 48 HRS |
| Due to (or as a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

1. CERVICAL CANCER
2. SUSPECTED TRANSFUSION RELATED ACUTE LUNG INJURY VERSUS HEART FAILURE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 ☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| RESIDENT EM/IM-3 | P15839 | 12/19/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. GREENE ST DEPT OF MEDICINE BALTIMORE, MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41410

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): FLORENCE FLINT
2. Date of Death Month / Day / Year: DEC 20 2003
3. Time of Death: 0328 A M
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN, MD
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 213-18-7806
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 20, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3409 Lord Baltimore Drive
10f. Zip Code: 21244
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 6
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector
16b. Kind of Business/Industry: Industrial

17. Father's Name (First, Middle, Last): John L. Carroll
18. Mother's Name (First, Middle, Maiden Surname): Florence Zeller

19a. Informant's Name/Relationship (Type, Print): Joseph John Kramer
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 403 Foster Knoll Drive Joppa, Md 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: 12/24/2003
20c. Location - City or Town, State: Woodlawn, Md

21. Signature of Funeral Service Licensee: Chester Wise
22. Name and Address of Facility: Loring Byers Funeral Directors 8728 Liberty Road Randallstown, Maryland 21133

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC ADENOCARCINOMA OF LUNG

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of Certifier: MD
29c. License number: D53910
29d. Date signed (Month, Day, Year): DEC 20, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. MAHESHWARI MD, NORTHWEST HOSPITAL, RANDALLSTOWN, MD

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41411

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HENRY FENZEL
2. Date of Death: Month December Day 17 Year 2003
3. Time of Death: 1200PM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN, MD
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 220-07-5924
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): May 5, 1921
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Lochearn
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3818 Cedar Drive
10f. Zip Code: 21207
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W.II 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Car foreman
16b. Kind of Business/Industry: Western Maryland Rail Road

17. Father's Name (First, Middle, Last): Harry George Fenzel
18. Mother's Name (First, Middle, Maiden Surname): Louise Joseph Thielke

19a. Informant's Name/Relationship (Type, Print): Mrs. Jean Mary Fenzel (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3818 Cedar Drive Locheard, MD 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cemetery
Date: Dec. 29, 2003
20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: Joseph J Kellner M00333
22. Name and Address of Facility: Loring Byer Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133-4784

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
BLADDER CANCER

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D58933
29d. Date signed (Month, Day, Year): December 17, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KERI M JOSEPH MD 5401 OLD COURT RD RANDALLSTOWN, MD 21133

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41412

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Althea Foreman
2. Date of Death (Month, Day, Year): December 23 2003
3. Time of Death: 0520 M
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 210-16-0927
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/2/1927
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8075 Wallace Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8 Years
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Samuel Pyle
18. Mother's Name (First, Middle, Maiden Surname): Elsie Shroeder

19a. Informant's Name/Relationship (Type, Print): Mark Foreman (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 212 Pinewood Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery Date: 12/24/2003
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Respiratory failure
Due to (or as a consequence of):
b. COPD
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Colitis
SIKS
Breast Cancer

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: P18065
29d. Date signed (Month, Day, Year): 12/22/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Eberlin MD 4940 Eastern Avenue, Baltimore, MD 21224

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 44413

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Nina Alice Fritsch

2. Date of Death: Month DEC Day 17 Year 2003

3. Time of Death: 8:05 P M

4a. Facility Name (If not institution, give street and number): STAGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: 184-54-8818

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 27, 1912

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Linthicum

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 211 West Maple Road

10f. Zip Code: 21090

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Black

18. Mother's Name (First, Middle, Maiden Surname): Flora Lippert

19a. Informant's Name/Relationship (Type, Print): Mr. Ralph James Fritsch / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 211 West Maple Road, Linthicum, MD 21090

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chartiers Cemetery

Date: Dec 20,2003

20c. Location - City or Town, State: Carnegie, PA

21. Signature of Funeral Service Licensee: [signature] M01319

22. Name and Address of Facility: Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL ISCHEMIA — Approximate Interval Between Onset and Death: 7 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. BILIARY SEPSIS — 10 days

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D14515

29d. Date signed (Month, Day, Year): DEC 17 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JENNIFER MARTIN 900 CATON AVE BALTIMORE MD 21229

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FRITSCH, NINA R

5

DHMH 17 Rev 1/2001

ORIGINAL

Paul. Geoghegan
03-08223
RJ

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM 23a,27 &28a-f PER ME G827 1/06/04 JH

# Certificate of Death

Reg. No. 2003 41414

2850

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| PAUL P. GEOGHEGAN | December 21, 2003 | 0740 P.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1805 BELT STREET | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-94-1310 | 1[X] M 2[ ] F | 34 Yrs. | | | April 15 1969 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | n/a | Baltimore | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1805 Belt Street | 21230 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | Clerk | Lucky's Superette |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Irvin C. Geoghegan | Alice M. Hilton |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Irvin C. Geoghegan (Father) | 1805 Belt Street, Baltimore, Md. 21230 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | Harbough Cem. Assoc. | 12/26/2003 | Rouzerville, Pa. |

21. Signature of Funeral Service Licensee: Paul L. Brunk

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ALCOHOL AND NARCOTIC INTOXICATION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1[ ] Yes 2[X] No 9[ ] Unknown | 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1[X] Yes 2[ ] No | 1[X] Yes 2[ ] No |

25. Was case referred to medical examiner? 1[X] Yes 2[ ] No

26. Place of Death (Check only one) — Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA — Other: 4[ ] Nursing Home 5[ ] Residence 6[X] Other (Specify) At scene

27. Manner of Death: 1[ ] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation [XX] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| found 12/21/03 | found 7:40p M | 1[ ] Yes 2[XX] No | UNKNOWN |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| FOUND IN RESIDENCE | 1805 BELT STREET BALTIMORE, MD. |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1[ ] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Theodore M. Kiyonaga | O.C.M.E. | December 22, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. Kiyonaga 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41415

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ANNA MARIE HEIM | December 19, 2003 | 12:15 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1233 Hull Street | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-03-9357 | 1☐ M 2☒ F | 86 Yrs. | | | Apr 14, 1917 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1233 Hull Street | 21230 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | 0 | Cleaning Maintenance | Metropolitan Life Insurance Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Anthony Polomski | Catherine Burdinski |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joseph Allum (Grandson) | 1235 Hull St., Baltimore, Md. 21230 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Holy Rosary Cemetery | 12/22/03 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Kevin E Ecker | McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave., Baltimore, Md. 21230 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRYTHMIA. — One Hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — Fifty Years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown | 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA, DEMENTIA.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? 1☐ Yes 2☑ No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No |
|---|---|

| 25. Was case referred to medical examiner? 1☐ Yes 2☑ No | 26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify) |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| A. Afroze Muneer MD | D45105 | 12/22/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AFROZE MUNEER MD 401 E. FORT AVE BALTIMORE 21230

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**Division of Vital Records, P.O. Box 68760,**

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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41416

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): TANISHA BRADLEY HODGE
2. Date of Death (Month, Day, Year): DECEMBER 15, 2003
3. Time of Death: 4:20 AM

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: None
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours: 1 / Min.: 23
8. Date of Birth (Month, Day, Year): December 15 2003
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1702 South Lemmon Street
10f. Zip Code: 21202
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 0
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Infant
16b. Kind of Business/Industry: Infant

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Tahkemia Hodge

19a. Informant's Name/Relationship (Type, Print): NIKKI CHILCOAT GBMC PATHOLOGY
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6701 N. Charles St. Towson, MD 21204

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREENMOUNT CEMETERY
Date: 12/18/2003
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: ▶ E.J. MONAZO
22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 16924 YORK RD, MONKTON MD 21111

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Extreme prematurity — 100 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month: 12 Day: Year:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D52011
29d. Date signed (Month, Day, Year): 12/15/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Victoria Dowling, M.D., 8028 Ritchie Highway, Pasadena MD 21122

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature: ▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

TANISHA BRADLEY HODGE

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41417

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Ernest William Hope | December 16, 2003 | 8:36 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical Center | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 016-28-5081 | 1 X M 2 ☐ F | 67 Yrs. | | | Aug. 24, 1936 | Massachusetts |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Gambrills | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2262 Dairy Farm Road | 21054 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1954-57 | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Draftsman | Engineering |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Thomas Hope | Mary Penfornis |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Renee Marie Hope/ Wife | 2262 Dairy Farm Road Gambrills, Maryland 21054 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | West Arundel Crematory | 12/17/2003 | Odenton, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Juanita R Thomas M00957 | Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Aortic Dissection | |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Coronary Artery Disease | |
| Due to (or as a consequence of): | | |
| | c. Abnormal Vascular Ischemia and Necrosis | |
| Due to (or as a consequence of): | | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD Surgical Resident | # 16547 | December 22, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
649 Millbrook Ct. Baltimore, MD 21236

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41418

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| PATRICIA | A. | HART | DECEMBER 18 2003 | 10:05P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 507 SHIPLEY ROAD | LINTHICUM | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 192-30-7762 | 1☐M 2☒F | 66 Yrs. | | | 8-17-1937 | NJ |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Linthicum | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 507 Shipley Road | 21090 | U.S.A |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) 5+ | Teacher | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Daniel Pettyjohn | Evelyn VanAken |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Tracy Lee / Daughter | 526 Hawthorne Road Linthicum, MD 21090 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | St Paul's Cemetery | Dec 23, 2003 | Clearspring, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Tyler Clymer M01195 | SINGLETON FUNERAL HOME P.A. 1 SECOND AVENUE S.W. GLEN BURNIE MD. 21061 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ESOPHAGUS CANCER | 9/5/03 |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. BREAST CANCER | 6198 |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

☒1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D37111 | 12/19/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

606 HAMMONDS LN V6, BALTIMORE MD 21225

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #7&18 PER FH G827 1/05/04 JH

# Certificate of Death

Reg. No. 2003 41419

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Wilbur Joseph Hipsley | December 19 2003 | 10:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Agnes Health Care | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-12-8695 | 1☒M 2☐F | ~~78~~ 79 Yrs. | | | 01/26/1924 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1212 Elm Ridge Ave. | 21229 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | Inspector | Canning |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Wilbur Hipsley | ~~Unknown~~ MARY CURRID |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Helen Hipsley/Wife | 1212 Elm Ridge Ave, Baltimore, MD 21229 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Loudon Park Cemetery | 12/22/2003 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Peter S. Ashton | Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. BACTERIAL PNEUMONIA | 14 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE
CORONARY ARTERY DISEASE
CONGESTIVE HEART FAILURE

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No ~~3☐~~ Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | 040012 | DECEMBER 19, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SCOTT POULSON, MD, 405 FREDERICK ROAD, SUITE 201, CATONSVILLE, MD 21228

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41420

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Eric Holler

2. Date of Death: Month 12 Day 6 Year 03

3. Time of Death: 3:00 PM

4a. Facility Name (If not institution, give street and number): (home) 507 Forest Lane

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 235-40-4839

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): 11/26/1926

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 507 Forest Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Clare Coffman

18. Mother's Name (First, Middle, Maiden Surname): Eliza Nestor

19a. Informant's Name/Relationship (Type, Print): Robert D. Holler/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 507 Forest Lane Baltimore, MD 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Mem. Park

Date: 12/19/2003

20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. oral cancer — Approximate Interval: =1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) ___ 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

polycythemia vera

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Jablonove MD

29c. License number: D41812

29d. Date signed (Month, Day, Year): 12/18/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Jablonove MD 419 W. Redwood St, Suite 620, Baltimore, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41421

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| August Louis Herring Jr. | December 21, 2003 | 4:20 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Franklin Square Hospital | Rosedale | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-22-3751 | 1☒M 2☐F | 74 Yrs. | | | 4/27/1929 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | White Marsh | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5032 Springhouse Circle | 21237 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | Truck Driver | Kelly Truck Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| August L. Herring Sr. | Mary (Unknown) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Diane Burinsky/Daughter | 5032 Springhouse Circle Baltimore, Maryland 21237 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Garden of Faith | 12/24/03 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Jessica Hoge | Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pulmonary Edema | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Cardiomyopathy | |
| | Due to (or as a consequence of): | |
| | c. Peptic Ulcer disease | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D0055034 | 12/21/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Jacques Conaway 9000 Franklin Square Drive Baltimore, Md. 21237

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | [signature] |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Herring August

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41422

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Robert Houston Holsclaw
2. Date of Death (Month, Day, Year): December 18, 2003
3. Time of Death: 2:25 A M
4a. Facility Name *(If not institution, give street and number)*: 5949 Benton Heights Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-18-6804
6. Sex: 1 ☐ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11/11/1925
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 5949 Benton Heights Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintanence Mechanic
16b. Kind of Business/Industry: Brewery

17. Father's Name *(First, Middle, Last)*: Charles M. Holsclaw
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth McCann

19a. Informant's Name/Relationship *(Type, Print)*: Thomas E. Holsclaw
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3807 Hebron Terrace Abingdon, Maryland 21009

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery
Date: 12/20/03
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206

**Physician /Medical Examiner**

23a. Part1. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 7 month.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Bronchiectasis — 10 years
c. Due to (or as a consequence of): Chronic obstructive lung disease — 10 years
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other *(specify)* 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier ▶
29c. License number: D5545
29d. Date signed *(Month, Day, Year)*: 12/18/2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Phil Buescher MD Union Memorial Hospital

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 23 2003
32. Registrar's Signature ▶

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41423

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| ROBERT | JOYNER | | 12 | 20 | 2003 | 1958 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HOWARD COUNTY GENERAL HOSP | COLUMBIA | HOWARD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-40-7325 | 1☒M 2☐F | 60 Yrs. | | | 10/13/43 | North Carolina |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Howard | Jessup | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8029 Lincoln Drive | 20794 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Fork Lift Operator | Mineral Pigments |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Moses Joyner | Addie Lee Williams |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Doris Kelly - Sister | 8029 Lincoln Drive Jessup, Maryland 20794 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Meadowridge Mem. Park | 12/26/03 | Elkridge, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Mgr. Hardman | Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial infarction | Minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Type 2 Diabetes | years |
| | c. Due to (or as a consequence of): Congestive Heart failure | years |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D0032753 | 12/23/03 |

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

8871 Gorman Rd Laurel MD 20723

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41424

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Ralph | W. | Jenkins | 12 | 22 | 2003 | 4:30 am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Franklin Square Hospital Center | Rosedale | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 216-34-6733 | 1 [X] M 2 [ ] F | 65 Yrs. | | | | | May 19, 1938 | WV. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Baltimore | Dundalk | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 1955 Frames Avenue | 21222 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grede completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 10 years | | Painter | Commercial |

| 17. Father's Neme (First, Middle, Lest) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Ralph W. Jenkins | Lillian V. Frazier |

| 19a. Informent's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Michael Jenkins son | 1404 Halkirk Way, Belair, MD. 21015 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify) | Meadowridge Cemetery | December 30, 2003 | ELkridge, MD. |

21. Signature of Funeral Service Licensee: ▶ Anthony C. Connelly

22. Name and Address of Facility: Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, MD. 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Ceuse (Final disease or condition resulting in death) a. | Sepic Shock | 1 day |
| Due to (or as e consequence of): b. | Pneumonia | 3 days |
| Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last: Due to (or es e consequence of): c. | | |
| Due to (or as e consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [/] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [/] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [/] No | Hospital: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) |

29a. Certifier (Check only one): 1 [/] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

| 29b. Signature end title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Yeer) |
|---|---|---|
| ▶ James F. Hale MD. | D0057721 | 12/22/03 |

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): 9000 Franklin Square Drive Baltimore, Md 21237

**State Registrar**

| 31. Dete filed (Month, Day, Year) | 32. Registrer's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] B. Sparks |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

Jenkins, Ralph

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41425

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Arthur Nelson Jenkins | December 17, 2003 | 8:20 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1132 Montpelier St. | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 227-24-2787 | 1☒ M 2☐ F | 79 Yrs. | | | Sept. 9, 1924 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1132 Montpelier St. | 21218 | U. S. A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7th Grade | | Tree Surgeon | Tree Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Mahlon Jenkins | Essie Taylor |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Shirley Jenkins (Sister-in-law) | 2517-229th St., Pasadena, Maryland 21122 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Oaklawn | 2/20/2003 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Brian A. Miller | Schimunek Funeral Homes 3331 Brehms Lane, Baltimore, Maryland 21213 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory viral illness — Approximate Interval Between Onset and Death: 2 days

Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. UREMIA

Due to (or as a consequence of):

c. END STAGE RENAL DISEASE — 2years

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease
Hypertension
Hypothyroid, Adenomatosis Colon

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Alicia A. Cool MD | D0030717 | 12/19/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alicia A. Cool MD 6701 N Charles St Suite 524 Baltimore MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41426

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| EVELYN AGNES JONES | December 19 2003 | 3:10P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Doctors' Community Hospital | Lanham | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 231.44.6121 | 1☐ M 2☒ F | 73 Yrs. | | | Feb. 2, 1930 | North Carolina |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George's | Lanham | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5207 Galveston Road | 20706 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11th | | Sales Associate | Retail Store |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| David T. Lawrence, Sr. | Dozella Bullock |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Bobbie J. Drummond/Daughter | 5207 Galveston Road, Lanham, Maryland 20706 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Fort Lincoln Cemetery | 12/23/2003 | Brentwood, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Nancy A. Percentie | FORT LINCOLN FUNERAL HOME 3401 Bladensburg Road, Brentwood, Maryland 20722 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute cerebrovascular Accident | 4 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation, Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D 20079 | 12/20/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don H. Yablonski, MD 7704 Executive Pl. Pl. Suite Lanham, MD 20706

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | Donna B. Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Evelyn Agnes Jones

DOS
3-8191
Richard Jones

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41427

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Richard Jones | December 20 2003 | 1054 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Johns Hopkins Bayview | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-46-6356 | 1☑M 2☐F | 57 Yrs. | | | Jan 19, 1946 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2507 Foster Ave | 21224 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | Carpenter | Union |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Jones | Evelyn Pettingill |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Nancy P. Jones/wife | 2507 Foster Ave, Baltimore, MD 21224 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | Dec 23 2003 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] 100986 | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Hypertensive Atherosclerotic Cardiovascular disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | December 22 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK McTitus, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | [signature] |

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41428

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Joseph Edward Kreft, Sr. | Dec. 21, 2003 | 9:45 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Little Sisters of the Poor | Catonsville | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-22-9230 | 1 X M 2 ☐ F | 76 Yrs. | | | July 14, 1927 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Carroll | Finksburg | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2803 Armacost Ave. | 21048 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 1 | Sales Representative | General Electric |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John A. Kreft, Sr. | Lucy B. Pilkerton |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Elizabeth A. Kreft - Wife | 2803 Armacost Ave., Finksburg, Md. 21048 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Evergreen Mem. Gardens | Dec. 29, | 2003 Finksburg, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ H. Eckhardt | Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. 21117 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): -Dementia | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and Title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Baskaran | D21649 | Dec 23, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMBANDAM BASKARAN 3455 WILKENS AVE, BALTIMORE MD 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | Lynne D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other then 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41429

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Charles Kilczewski | December 16, 2003 | 9:15 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 11922 Frost Valley Way | Potomac | Montgomery |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 222-22-1876 | 1 X M 2 ☐ F | 68 Yrs. | | | July 7, 1935 | Pennsylvania |

**Funeral Director**

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Montgomery | Potomac | 1 ☐ Yes 2 XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11922 Frost Valley Way | 20854 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 1 XX Yes 2 ☐ No If Yes, Give Year or Dates: 1958 | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Professional Coach | Coach |
| | 5+ | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Kilczewski | Helen Palczewski |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Suzanne Kilczewski/ Wife | 11922 Frost Valley Way, Potomac, MD 20854 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Baltimore Crematory at LP | 12/19/03 | Baltimore, MD |

21. Signature of Funeral Service Licensee ▶ D. Holland

22. Name and Address of Facility: Simple Tribute Funeral and Cremation Center 1040 Rockville Pike Rockville, MD 20852

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Gastric Carcinoma | 8 Months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 XX No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 XX No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify)

27. Manner of Death 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Mark Kavalier | DC 6954 | 12/16/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. M. Kavalier 1120 19th Street, N.W., Washington, DC 20036

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

**Baltimore, Maryland 21215-0036**
**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Rec'd 12/16/03

Kilczewski, Charles

6+1

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar AMEND ITEM #23b PER PHY G826 12/23/03 JH

# State of Maryland / Department of Health and Mental Hygiene
## Certificate of Death

Reg. No. 2003 41430

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| LOUISE | RUTH | KING | DECEMBER | 12 | 2003 | 02:00P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 102 N.CRAIN HWY. #922 | GLEN BURNIE | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-40-6770 | 1☐ M 2☒ F | 85 Yrs. | | | 09/26/1918 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | ANNE ARUNDEL | GLEN BURNIE | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 102 N. CRAIN HWY. #922 | 21061 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | HOMEMAKER | HOME OWNER |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| FREDERICK NEWTON | ETHEL (UNKNOWN) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MR. CLEMENT KING, JR./SON | 214 DITTY COURT GLEN BURNIE, MD 21060 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | GLEN HAVEN MEMORIAL PARK | 12/16/03 ~~09/26/2003~~ | GLEN BURNIE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] M01364 | SINGLETON FUNERAL HOME,P.A. 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiopulmonary arrest | immediate |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. ADULT ONSET DIABETES MELLITUS | |
| | c. | |
| | d. | |

Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

~~Adult onset diabetes mellitus~~, hypertension, hyperlipidemia, edema

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Candace Chandler MD | D29209 | 12/15/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Candace Chandler MD 8096 Edwin Raynor Blvd Pasadena MD 21122

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41431

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Fred T Kelley | December 19 2003 | 6:52 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Gilchrist Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218 01 8098 | 1☐M 2☐F X | 86 Yrs. | | | August 28 1917 | Kitzmiller,MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore County | 1☐Yes 2☐No X |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5613 North Lane | 21206 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | N/A | Auto Mechanic | Auto Dealer |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Dorsey E Kelley | Mary Foust |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ruby Kelley (Wife) | 5613 North Lane Baltimore, Maryland 21206 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gardens of Faith Cem. | December 22 2003 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Charles Lessner Chojnacki | Lessner Funeral Home Inc. 7401 Belair Road Baltimore, Maryland 21236 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Prostate cancer | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M Anthony Riley, MD | D5005 | December 20, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley G BMC 6701 N. Charles St. Balto. Md 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760,**

@652 PM

Kelley, Fred, FRIDAY, December 19th, 2003

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar AMEND ITEM #23PII PER PHY G826 12/23/03 JH

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41432

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Mary C. Kozak | December 21, 2003 | 10:50 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Stella Maris Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 200-07-5909 | 1☐M 2☒F | 90 Yrs. | | | Jan. 10, 1913 | Slovakia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Towson | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2300 Dulaney Valley Road | 21093 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married ☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 Years | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Stephen Chiprich | Mary Kimac |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gerald Kozak (Son) | 3248 Montebello Dr. West Colorado Springs, CO 80918 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | St. Michael Cemetery | 12/29/2003 | Donora, PA |

21. Signature of Funeral Service Licensee: ▶ Donald C. Cayll

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. [illegible] | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): [illegible] | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- [illegible]
- [illegible]

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [illegible] MD | D 15504 | 12.22.03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [illegible] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

MARY KOZAK DECEMBER 21, 2003 10:50 A.M.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41433

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| WILLIAM | | KEIBLER | DECEMBER 20 2003 | 03:11AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHNS HOPKINS BAYVIEW MEDICAL CENTER | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-30-5857 | 1☒ M 2☐ F | 67 Yrs. | | | July 21,1936 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore City | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3432 Mt. Pleasant Ave. | 21224 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 Years | | Foreman | Patapsco Back River Rail Road |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William M. Keibler, Sr. | Amelia Unkn. |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Loretta M. Keibler(Wife) | 3432 Mt. Pleasant Ave. Baltimore, Maryland 21224 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Oak Lawn Cemetery | 12/23/2003 | Baltimore, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | 12 Hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. LIVER FAILURE | 6 MONTHS |
| | c. | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | RES-000 | DECEMBER 20, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHRISTINE TOMPKINS 4940 EASTERN AVE BALTIMORE MD 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | [signature] |

ORIGINAL

DHMH 17 Rev 1/2001

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41434

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Agnes Lockwich | December 16, 2003 | 5:27 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Agnes Healthcare | Baltimore | Not Applicable |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-28-1784 | 1☐ M 2☒ F | 70 Yrs. | | | Jan. 22, 1933 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6029 Montgomery Street | 21207 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Tavern Owner | Tavern |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Adam Andrzejczuk | Stella Dzieciatko |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Edward Lockwich (Husband) | 6029 Montgomery Street, Baltimore, Maryland 21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Loudon Park Cemetery | 12/20/2003 | Baltimore, Maryland |

| 21. Signature of Funeral Service License: | 22. Name and Address of Facility |
|---|---|
| ▶ | Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Probable Acute Myocardial Ischemia | Minutes |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Coronary Atherosclerosis | Years |
| | Due to (or as a consequence of): | |
| | c. Atherosclerotic Cardiovascular Disease | Years |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cardiomegaly with left ventricular hypertrophy

(Hypertensive Cardiovascular disease)

Probable (terminal) aspiration

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒ Yes 2☐ No | 1☒ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Kris M. Shekitka MD | D0037359 | December 16, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRIS M. SHEKITKA MD ST. AGNES HEALTHCARE – 900 CATON AVE, BALTIMORE, MD 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #13 per fh 6826 12/23/03 tas

# Certificate of Death

Reg. No. 2003 41435

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| LOUIS ROBERT LEE | DECEMBER 20 2003 | 2:35 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HOSPICE OF BALTIMORE-GILCHRIST CENTER TOWSON | | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 137-38-3294 | 1 X M 2 ☐ F | 55 Yrs. | | | DEC 28 1947 | NJ. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2311 SUGARCONE ROAD | 21209 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates: | ~~X~~ Yes X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | PROPRIETOR | UNIFORM COMPANY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| DANIEL LEE | NATALIE ROSENCRANTZ |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. JAYNE LEE/WIFE | 2311 SUGARCONE ROAD BALTIMORE, MD.21209 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory, or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | SWINICHER-WOLINER BENEVOLENT SOC. ASSOC. | 12/21/2003 | BALTIMORE, MD. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE,MD.21208

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Bladder cancer — Due to (or as a consequence of): — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) Hospice

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D25005 | December 20, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley GSMC 6701 N. Charles St. Balto. Md 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

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Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

2:35am

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12/20/03

Division of Vital Records, P.O. Box 68760,

Lee, Louis

2

1

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41436

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| CLARA | LAZARUS | DECEMBER 19, 2003 | 5:20 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HEBREW HOME OF GREATER WASHINGTON | ROCKVILLE | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 081-36-2705 | 1 ☐ M 2 ☒ F | 87 Yrs. | | | NOV. 30, 1916 | POLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | MONTGOMERY | ROCKVILLE | 1 ☒ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6121 MONTROSE ROAD | 20852 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12): 12 | College (1-4or 5+) | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| MICHAEL KHARP | LEAH WEICH |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| LEON LAZARUS / SON | 11 STONELEA DRIVE - PRINCETON JUNCTION, NJ 08550 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | PARK KING SOLOMON MEMORIAL | 12/23/2003 | CLIFTON, NJ |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Scott M. Attlin | SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCT — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, TYPE 2

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D18084 | DECEMBER 19 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE MD 20852

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | [signature] |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LAZARUS, CLARA

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41437

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GILDA T. LERNER
2. Date of Death Month: DECEMBER Day: 19 Year: 2003
3. Time of Death: 10:30 PM
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-28-7803
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 17, 1932
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3041 FALLSTAFF ROAD APT. 507
10f. Zip Code: 21209
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): HERMAN ROSENTHAL
18. Mother's Name (First, Middle, Maiden Surname): RAE GOODMAN

19a. Informant's Name/Relationship (Type, Print): MR. IRVING B. LERNER/HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3041 FALLSTAFF ROAD APT. 507 BALTIMORE, MD. 21209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BNAI ISRAEL CONG.
Date: 12/21/2003
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: ▶ Edward C. Rusk
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE. MD. 21208

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — Approximate Interval Between Onset and Death: 3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Rheumatoid Arthritis

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ P Caimi M.D.
29c. License number: RES-000
29d. Date signed (Month, Day, Year): 12/18/2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAOLO CAIMI M.D., SINAI HOSPITAL OF BALTIMORE

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature: ▶

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

PATIENT KNOWN AS GILDA LERNER.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41438

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Joseph C. McCormick | Dec. 21, 2003 | 3:20am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Continuum Care | Sykesville | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-16-7123 | 1☐M 2☐F X | 80 Yrs. | | | Dec. 10, 1923 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Carroll | Eldersburg | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1333 Companion Drive | 21784 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: WWII | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) 8 | Electrician | Electrical |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James P. McCormick | Josephine Gutlieb |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Alberta S. McCormick (Wife) | 1333 Companion Drive Eldersburg, MD 21784 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | All County Cremation | 12/22/03 | Sykesville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Brian L. Haight | HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. C. V. A

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Dysphagia

Due to (or as a consequence of):
c. HTN

Due to (or as a consequence of):
d. Renal Failure

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No |
|---|---|

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ RM Kamen MD | D-0054218 | 12-22-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. Raman B Kemeny, 399 Malcolm drive, Westminster MD 21157

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Shaun Alan McManamey
03-08084
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Unpend Items#23a,27,28A-F PERMEOG827 1/02/2004 EW

# Certificate of Death

Reg. No. 2003 41639

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Shaun Alan McManamey | December 15, 2003 | 10:05 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 9984 Sherwood Farm Road | Owings Mills | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 382-74-6878 | 1 [X] M 2 [ ] F | 31 Yrs. | | | Apr. 20, 1972 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Baltimore | Owings Mills | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9984 Sherwood Farm Rd. | 21117 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1990-1994 | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4 | Nurse | Hospital |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Robert McManamey | Claudia Lynn Light |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| James R. McManamey - Father | 4466 Dale Blvd., Dale City, Virginia 22193 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Quantico National Cem. | Dec. 22, 2003 | Triangle, Virginia |

21. Signature of Funeral Service Licensee: ▶ H. Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. 21117

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Manner of Death 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| Found 12/15/03 | Found 10P M | 1 [ ] Yes 2 [X] No | Unknown |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found at Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 9984 Sherwood Farm Road Owings Mills, Maryland

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ LING LI, M.D | O.C.M.E. | December 16, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LING LI, M.D 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41440

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Eva June McGehee | DECEMBER 20 2003 | 15:26 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Upper Chesapeake Hospital | Bel Air | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-20-3699 | 1 ☐ M 2 ☒ F | 79 Yrs. | | | June 3, 1924 | Pennsylvania |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Bel Air | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 205 D Burkwood Court | 21015 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Domestic |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles W. Gardner | Olive B. Swartzwelder |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Deitz - Daughter | 2915 Harper Drive, Finksburg, Maryland 21048 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Meadowridge Memorial | 12/23/03 | Elkridge, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Kathleen Weber CFSP | David J. Weber Funeral Homes, P.A. 5311 Edmondson Ave., Baltimore, Maryland 21229 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. DIFFUSE FOLLICULAR LYMPHOMA 6 MONTHS

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| John P. Edwards MD | D31775 | DECEMBER 20, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHN P. EDWARDS, MD 2112 BELAIR ROAD FALLSTON, MARYLAND 21047

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | Deanna D. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

McGehee, Eva June

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41441

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Sarranda Miller
2. Date of Death Month: December Day: 21 Year: 2003
3. Time of Death: 1225 P M
4a. Facility Name (If not institution, give street and number): Mercy Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212-30-2616
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/26/1933
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2629 Dulany Street
10f. Zip Code: 21223
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Line Worker
16b. Kind of Business/Industry: Factory

17. Father's Name (First, Middle, Last): Townie Cronkilton
18. Mother's Name (First, Middle, Maiden Surname): Rosalie Whitcomb

19a. Informant's Name/Relationship (Type, Print): Helen Dugas / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8605 Jessica Lane Perry Hall, Maryland 21128

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 12/24/2003
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber
22. Name and Address of Facility: David J. Weber Funeral Homes PA 5311 Edmondson Avenue Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. congestive heart failure — Approximate Interval Between Onset and Death: months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal failure, Respiratory failure, Atherosclerotic cardiovascular disease

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Nevins W. Todd MD
29c. License number: D37790
29d. Date signed (Month, Day, Year): December 21, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nevins W. Todd 301 St Paul Place Baltimore MD 21202

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature: [illegible]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM 28a PER PHY G826 12/23/03 CF

Reg. No. 2003 41442

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jesse Mc Daniel
2. Date of Death: Month 12 Day 21 Year 2003
3. Time of Death: 0327 AM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview medical center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 434-20-4048
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 10, 1918
9. Birthplace (State or Foreign Country): Louisiana

Usual Residence of Decedent

10a. State: MD.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7306 School Avenue
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Beth Steel

17. Father's Name (First, Middle, Last): Jesse Mc Daniel
18. Mother's Name (First, Middle, Maiden Surname): Evie Mattie Caulk

19a. Informant's Name/Relationship (Type, Print): Florene Mc Daniel wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7306 School Avenue, Dundak, Md. 21222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cemetery
Date: December 24, 2003
20c. Location - City or Town, State: Rosedale, Md.

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — 7 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
CHRONIC RENAL INSUFFICIENCY

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): ~~12/21/2003~~
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D0056957
29d. Date signed (Month, Day, Year): 12/21/2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William T Hosek MD Johns Hopkins Bayview Medical Cntr

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41443

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Ethel Lee McGraw | December 18, 2003 | 12:10a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Mariner Health of Forest Hill | Forest Hill | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-10-1198 | 1☐ M 2☒ F | 85 Yrs. | | | June 27, 1918 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Harford | Abingdon | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 20 Box Hill S. Pkwy., Apt. 122 | 21009 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 years | | homemaker | own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James William Miller | Bessie Lee Valentine |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Kathleen Scott/daughter | 2006 Tiffany Terrace, Forest Hill, MD 21050 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Bayview Crematory | 12/20/03 | Baltimore, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. pneumonia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Menner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D 32755 | December 19 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David S. Dunn 605 W. MacPhail Rd. Bel Air MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41444

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): OLIVE T. McGREEVY

2. Date of Death: Month: Dec Day: 20 Year: 2003

3. Time of Death: 10:15AM

4e. Facility Name (If not institution, give street and number): Mariner Health of Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 218-01-1363

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/13/1910

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Pylesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1033 Old Pylesville Road

10f. Zip Code: 21132

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Lest): Thomas Troy Turner

18. Mother's Name (First, Middle, Maiden Surname): Ella Mae Leight

19a. Informant's Name/Relationship (Type, Print): Marie Curry/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1403 Balsam Court, Forest Hill, MD 21050

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Slate Ridge Cemetery

Date: 12/22/03

20c. Location - City or Town, State: Delta, PA

21. Signature of Funeral Service Licensee: Jeffrey P. Lovell

22. Name and Address of Facility: Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.
**Important: If Item 27 is marked other than "natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Dementia - Alzheimer's — 8 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of deeth? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D34652

29d. Date signed (Month, Dey, Yeer): December 20, 2003

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Scott Haswell 2 North Avenue Bel Air Maryland 21014

**To the Hospital or Attending Physician:** The law requiras that the death certificata be axecuted within 24 hours aftar death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely fillad in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Olive T. McGreevy

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

KEITH McKIM
03-8213
DAP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM #1,23a,27&28a-f PER ME G827 1/08/04 JH

# Certificate of Death

Reg. No. 2003 4445

2851

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ~~KEITH W. McKim~~ KEITH WILLIAM McKIM | DECEMBER 21,2003 | 8:20 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ROSSVILLE BLVD AT YELLOW BRICK RD | ROSEDALE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212 62 5833 | 1☒M 2☐F | 50 Yrs. | | | Aug. 21,1953 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore County | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 942 North Marlyn Avenue | 21221 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11th grade | N/A | Carpet Installer | Carpet Industry |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William I. McKim | Doris L. Wienecke |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Roger W. McKim (Brother) | 19633 Middletown Rd. Freeland Md. 21053 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| ☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gardens of Faith CEm. | 12-23-03 | Baltimore, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| E. J. Lassahn | Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE ALCOHOL INTOXICATION COMPLICATED BY HYPOTHERMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☒Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day Year) found 12-21-03

28b. Time of Injury found at 8:15a M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND AT RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State): ROSSVILLE BLVD& yellow brick RD. BALTIMORE,MD

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Zabiullah AL | OOME | DECEMBER 22,2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ZABIULLAH AL 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41446

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Lillian R. Milano

2. Date of Death (Month, Day, Year): Dec. 22, 2003

3. Time of Death: 7:55 AM

4a Facility Name *(If not institution, give street and number)*: Genesis Eldercare of Towson

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-16-8853

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 4, 1913

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1814 Loch Shiel Road

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles Fritz

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillie Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Michael A. Milano/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1814 Loch Shiel Rd. Baltimore, Maryland 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore National Cem.

Date: 12/24/03

20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: Michael Ruck

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. VAGINAL Bleeding — months

Due to (or as a consequence of):
b. Pelvic Neoplasm unspecified — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D17118

29d. Date signed *(Month, Day, Year)*: Dec. 22, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwaeft M.D. 7700 York Rd 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 23 2003

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41447

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Jessie L. MacKay | December 19, 2003 | 2:00 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 257 Carroll Rd. | Glen Burnie | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577-16-7616 | 1☐ M 2☒ F | 89 Yrs. | | | Nov.15, 1914 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Glen Burnie | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 257 Carroll Road | 21060 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | IBM Key Punch Operator | Social Security |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Duclos | Janet Sterling |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs.Janet E. Reaver/daughter | 21671 Wood Wharf Road Preston,MD 21655 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Cedar Hill Cemetery | Dec.23,2003 | Brooklyn Park, MD |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| [signature] | M01364 | Singleton Funeral Home 1 Second Ave SW, Glen Burnie, MD 21061 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Demontia | years |
| | c. | |
| | d. | |

Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☐ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] MD | D50725 | 12-22-2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jennifer Riedinger 8601 Veterans Hwy Millersville, MD 21108

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | [signature] |

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

CPM
03-08121
MARVIN MONK

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2003 4143

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Marvin Dean Monk
2. Date of Death (Month, Day, Year): December 17, 2003
3. Time of Death: 11:57 A M
4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 214-36-7918
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 23, 1938
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Forest Hill
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2301 Grafton Shop Road
10f. Zip Code: 21050
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1959-62
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Munitions Tester
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Frazier (nmn) Monk
18. Mother's Name (First, Middle, Maiden Surname): Chloe (nmn) Ferren

19a. Informant's Name/Relationship (Type, Print): Mary R. Monk - Personal Rep.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2100 Fairlane Road, Bel Air, Maryland 21015

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Mem. Gardens
Date: 12/23/03
20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Stephen A. Keech
22. Name and Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, Maryland 21014

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Complications of alcohol abuse
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Peritonitis due to pancreatic pseudocyst
Cirrhosis of the liver
cachexia

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 18, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10f1

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41449

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| FRANK NADOLNY | December 21, 2003 | 2.30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Johns Hopkins Bayview Medical Center | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-01-4646 | 1☒M 2☐F | 88 Yrs. | | | March 2, 1915 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Dundalk | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2609 McComas Ave. | 21222 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 Years | | Truck Driver | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Stephen Nadolny | Antoinette Wiatrowski |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Frank Nadolny, Jr. (Son) | 2609 McComas Ave. Dundalk, Maryland 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Sacred Ht. of Jesus Cem. | 12/26/2003 | Dundalk, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Hypercapnic Respiratory Failure | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Bilateral lower lobe pneumonia | |
| | c. Influenza | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation
Osteomyelitis
Cellulitis

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] Medical Doctor Housestaff | RES-000 | 12/21/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
4940 Eastern Avenue, Baltimore MD 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41450

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edith Eleanora Neuman
2. Date of Death Month/Day/Year: December 16 2003
3. Time of Death: 8:35 P M
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 215-24-7588
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): 08/01/1929
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7747 Outing Avenue
10f. Zip Code: 21122
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Edward Helmstetter
18. Mother's Name (First, Middle, Maiden Surname): Eleanor Louise Wieber
19a. Informant's Name/Relationship (Type, Print): Rose O'Connor/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 503 Sunset Knoll Rd.,Pasadena,MD 21122
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veterans Cem
Date: 12/22/03
20c. Location - City or Town, State: Crownsville,MD
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: G.J.Gonce Funeral Home,PA 169 Riviera Dr.,Pasadena,MD 21122

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Neuman, Edith
Baltimore, Maryland 21215-0036

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC OVARIAN CANCER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one) Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D45149
29d. Date signed (Month, Day, Year): December 16 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 301 Hospital Drive Glen Burnie MD 21061

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41451

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Richard Novasio

2. Date of Death: Month Dec Day 16 Year 2003

3. Time of Death: 345 PM

4a. Facility Name *(If not institution, give street and number)*: Lorien Nursing Home

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 528-30-1439

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: Sept. 3, 1929

9. Birthplace *(State or Foreign Country)*: North Dakota

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 2304 Westchester Avenue

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+): 4+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: School System

17. Fether's Name *(First, Middle, Last)*: Charles Novasio

18. Mother's Name *(First, Middle, Maiden Sumame)*: Hazel Richmond Johnsen

19a. Informant's Name/Relationship *(Type, Print)*: Hazel Novasio (Wife)

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 2304 Westchester Ave Catonsville, MD 21228

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Balto/Wash Crematory

Date: 12/23/03

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Bernard Witzke

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer — 12 wks

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. smoking

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy perlormed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Gary Kadow

29c. License number: D41617

29d. Date signed *(Month, Day, Year)*: Dec 16, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary Kadow MD 10805 Hickory Rd Ellicott City MD 21042

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 23 2003

32. Registrar's Signature

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours efter daath with the Maryland Department of Health end Mantal Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the daath certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate hes been signed by the attending physician end completely filled in by the funeral diractor, pege 2 should be detached for use es tha burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41652

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Norbert Charles Nitsch, Jr.

2. Date of Death: Month December, Day 20, Year 2003

3. Time of Death: 10:00A M

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-12-5858

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Feb. 24, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 715 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ____ College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Asst. Commissioner of Transit

16b. Kind of Business/Industry: City Government

17. Father's Name (First, Middle, Last): Norbert Charles Nitsch, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ethel Marie Katzenberger

19a. Informant's Name/Relationship (Type, Print): Virginia H. Nitsch (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 715 Maiden Choice Lane Catonsville, Maryland 21228

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Cemetery

Date: 12-23-2003

20c. Location - City or Town, State: Rock Hall, Maryland

21. Signature of Funeral Service Licensee: John Evans

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 9 ☐ Unknown

23d. Date of delivery: Month ____ Day ____ Year ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Asthma

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Evans MD

29c. License number: D0020040

29d. Date signed (Month, Day, Year): 12/22/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Evans MD 715 Maiden Choice Lane, Catonsville MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41453

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EDNA, E., ONEIL
2. Date of Death Month Day Year: DECEMBER, 20, 2003
3. Time of Death: 05:55 PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMOR CITY
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-03-0175
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 24, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1605 Harden Court
10f. Zip Code: 21230
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator
16b. Kind of Business/Industry: Maryland Cup
17. Father's Name (First, Middle, Last): Francis Suit
18. Mother's Name (First, Middle, Maiden Surname): Mary Strotman
19a. Informant's Name/Relationship (Type, Print): Barbara Bennaman (Niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1807 Belt St. Baltimore, Maryland 21230
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Mem. Pk.
Date: 12/23/03
20c. Location - City or Town, State: Glen Burnie, Maryland
21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave. Baltimore, Maryland 21230

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death): a. Pneumonia — Approximate Interval Between Onset and Death: 6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertention
Atrial Fibrilation

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No
25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier ▶ Mob Lemme MD
29c. License number: RES 000
29d. Date signed (Month, Day, Year): December, 20 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EYOB L. Feyssa 301 LORD BYRON LN #102, COCKEYSVILLE MD 21030

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature ▶

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item 12 per FH,G827,01/12/04dhb **Certificate of Death** Reg. No. 2003 41454

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Chidozie U. Olandu
2. Date of Death Month Day Year: 12-21-03
3. Time of Death: 2:05 AM
4a. Facility Name (If not institution, give street and number): 5638 Clearspring Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 212-15-1145
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 21 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9-12-82
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 5638 Clearspring Road
10f. Zip Code: 21212
10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Student

17. Father's Name (First, Middle, Last): Anthony U. Olandu
18. Mother's Name (First, Middle, Maiden Surname): Mary Okorafor

19a. Informant's Name/Relationship (Type, Print): Anthony U. Olandu (Father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7908 A. Westmoreland Ave. Balto. MD 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St Mary's Cemetery
Date: 12/27/03
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Vaughn Greene
Name and Address of Facility: Vaughn C. Greene Funeral Services 4405 York Road Balto. MD 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. ACUTE LYMPHOCYTIC LEUKEMIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: C. Vergara-Soares MD
29c. License number: D16619
29d. Date signed (Month, Day, Year): DEC. 23, 2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. VERGARA-SOARES 9940 FRANKLIN SQUARE DR. BALTIMORE, MD. 21236

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Medical Certification: To be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8897C

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item #7 per fh G826 12/25/03 tas

# Certificate of Death

Reg. No. 2003 41455

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Evelyn Orandle

2. Date of Death: Month December Day 18 Year 2003

3. Time of Death: 4:45pm

4a. Facility Name (If not institution, give street end number): GEC Randallstown 9109 Liberty rd. Randallstown 21133

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212-26-2835

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 95 ~~94~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yea): APR.23,1908

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: RANDALLSTOWN

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 9109 LIBERTY ROAD

10f. Zip Code: 21133

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): LOUIS FOREMAN

18. Mother's Name (First, Middle, Maiden Surname): SARAH (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): NANCY R. CHADWICK / DAUGHTER

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 9400 WORDSWORTH WAY #103 - OWINGS MILLS, MD 21117

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BETH ISAAC ADATH ISRAEL

Date: 12/21/03

20c. Location - City or Town, State: DUNDALK, MD

21. Signature of Funeral Service Licensee: Scott M. Cutler

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

HYPERLIPIDEMIA

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: KALU UMA M.D

29c. License number: D0059107

29d. Date signed (Month, Dey, Year): 12-19-03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KALU UMA, MD WESTSIDE MEDICAL GROUP, 2600 LIBERTY HEIGHTS AVENUE BALTIMORE MD 21215

**State Registrar**

31. Date filed (Month, Dey, Year): DEC 23 2003

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41456

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MARIE PARKER
2. Date of Death Month / Day / Year: DEC. 20 2003
3. Time of Death: 2:00pm M
4a. Facility Name *(If not institution, give street and number)*: 210 ALTAMONT AVENUE
4b. City, Town, or Location of Death: CATONSVILLE
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 141-22-9332
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEPT. 25, 1924
9. Birthplace *(State or Foreign Country)*: unk

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: CATONSVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 210 ALTAMONT AVENUE
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* AFRICAN AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TEACHER OF MUSIC
16b. Kind of Business/Industry: SCHOOL SYSTEM

17. Father's Name *(First, Middle, Last)*: unk
18. Mother's Name *(First, Middle, Maiden Surname)*: unk

19a. Informant's Name/Relationship *(Type, Print)*: DEBORAH HAMILTON (GUARDIAN)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1000 CATHEDRAL STREET BALTIMORE, MD 21201

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. ZION CEMETERY
Date: 12/22/03
20c. Location - City or Town, State: LANSDOWNE, MD

21. Signature of Funeral Service Licensee: Douglas M Wylie
22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Skin infection

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown
23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Anemia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anil Uberoi MD
29c. License number: D26748
29d. Date signed *(Month, Day, Year)*: 12/22/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANIL UBEROI MD 4419 FALLS RD BALTO MD 21211

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 23 2003
32. Registrar's Signature

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #19a PER FH G828 2/02/04 JH

# Certificate of Death

Reg. No. 2003 41457

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lucinda Ray

2. Date of Death (Month, Day, Year): December 16, 2003

3. Time of Death: 143 P M

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 174 20 7105

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 8, 1918

9. Birthplace (State or Foreign Country): ARK

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE, Maryland

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1313 E. NORTH AVE

10f. Zip Code: 21213

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cosmetology

16b. Kind of Business/Industry: Cosmetologist

17. Father's Name (First, Middle, Last): David James

18. Mother's Name (First, Middle, Maiden Surname): Lucille Gates

19a. Informant's Name/Relationship (Type, Print): PHILISTEAN RAY MAYFIELD Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1313 E North Ave Baltimore MD 21213

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Cemetery

Date: 12/31/03

20c. Location - City or State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Patricia Butts

22. Name and Address of Facility: BEHS Funeral Home 1124 N. Caroline St Baltimore, Maryland 21213

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Chronic End Stage Renal Disease

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mir Shafiee

29c. License number: 89500

29d. Date signed (Month, Day, Year): 12/16/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mir Shafiee, M.D. 40 Maryland General Hospital

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Lucinda Ray
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41458

Romanello J Robinson
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| ROMANELLO | J. | ROBINSON | December 11, 2003 | 6:18 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore City | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-14-8911 | 1☒ M 2☐ F | 83 Yrs. | | | July 27, 1920 | Unobtainable |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | | Baltimore City | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3809 Bell Avenue | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Year or Dates: Unknown | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| Unknown | | Unobtainable | Unobtainable |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Unobtainable | Unobtainable |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ronald Green/Care Provider | 3809 Bell Avenue, Baltimore, Maryland 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Fort Lincoln Cemetery | 12/22/2003 | Brentwood, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Nancy A. Pecantie | FORT LINCOLN FUNERAL HOME 3401 Bladensburg Road, Brentwood, Maryland 20722 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Aspiration Pneumonia | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lactic acidosis

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
- 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
- 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Rachel Hartman M.D | RES-000 | December 11, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rachel Hartman, M.D. Sinai Hospital of Baltimore

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] D. Spence |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41459

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Anna | S | Riley | Dec 18 2003 | 6:40 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Asbury Solomons Island | Solomons | Calvert |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-12-4723 | 1☐M 2☒F | 100 Yrs. | | | Feb. 14, 1903 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Calvert | Solomons | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11450 Asbury Circle #108 | 20689 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | Housekeeping | Towson University |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George J. Skipper | Lucy B. Stuller |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ralph G. Barrett / son | 11450 Asbury Circle #108; Solomons, MD 20689 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Poplar Grove Cemetery | 12/22/03 | Phoenix, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Peter V. Clay | Ruck Towson Funeral Home — 1050 York Road Towson, MD 21204 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Ischemic Cardiomyopathy | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ David J Tardio MD | 047610 | December 19, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D J Tardio, MD 11100 Asbury Circle; Solomons, MD 20688

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ Jeanne M. Grant |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item#20b,20cperFHG826 12/23/03 EW

# State of Maryland / Department of Health and Mental Hygiene
# Certificate of Death

Reg. No. 2003 41460

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Thomas Lee ROYALL | December 21, 2003 | 9:45 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3025 East Baltimore Street | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-78-7999 | 1☑M 2☐F | 42 Yrs. | | | Nov 15, 1961 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3025 East Baltimore Street | 21224 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☑Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Employment Specialist | Alliance Corporation |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Paul William Royall | Lillie Bernice Hardin |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| James Royall, Sr/Brother | 3029 East Baltimore Street, Baltimore, MD 21224 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | ST Stanislaus Cemetery ~~Mt. Carmel Cemetery~~ | Dec 26 2003 | Dundalk,Md ~~Baltimore, MD~~ |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] M00986 | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Liver Failure | 1 month |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Colon Carcinoma | 1 year |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No |
|---|---|

| 25. Was case referred to medical examiner? 1☐Yes 2☒No | 26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify) |
|---|---|

| 27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Charles Padgett MD | D15546 | Dec 22, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles Padgett MD 5601 Loch Raven Blvd Baltimore MD 21239

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41461

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Herbert L. Rogers
2. Date of Death: Month December Day 16th Year 2003
3. Time of Death: 12:15 a M
4a. Facility Name (If not institution, give street and number): Howard County General Hosp.
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 035-20-0493
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 6, 1929
9. Birthplace (State or Foreign Country): R.I.

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4994 Beaverbrook Road
10f. Zip Code: 21044
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Elec. Engineer
16b. Kind of Business/Industry: Defense Dept.

17. Father's Name (First, Middle, Last): James Herbert Rogers
18. Mother's Name (First, Middle, Maiden Surname): Beatrice Florence Wadlinger

19a. Informant's Name/Relationship (Type, Print): Patricia Miller/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1013 Courtland Drive, Eldersburg, Md. 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Cemetery
Date: 12/19/2003
20c. Location - City or Town, Stete: Ellicott City, Md.

21. Signature of Funeral Service Licensee: ▶ Bernard Dabrowski
22. Name and Address of Facility: Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd, Columbia, Md. 21045

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypernitremia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Sepsis
c. Due to (or as a consequence of): UTI urinary tract infection
d. Due to (or as a consequence of): Coronary artery disease

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: ▶ [signature]
29c. License number: D50870
29d. Date signed (Month, Day, Year): December 16th 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suzan Abdo 5005 Signal Bell Ln. Clarksville MD 21029

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature: ▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

Leslie Ryan
03-08136
crn

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM 23a,PII&27PER ME G827 1/21/04 JH

# Certificate of Death

Reg. No. 2003 41462

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Leslie Earl Ryan | December 18, 2003 | 7:05 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Upper Chesapeake Medical Center | Bel Air | Harford |

**Funeral Director**

2852

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 519-44-3975 | X 1 M 2 F | 62 Yrs. | | | Aug. 13, 1941 | California |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Edgewood | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 833 St. George Court | 21040 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 X Yes 2 No If Yes, Give Year or Dates 1969-73 | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Police Communications Officer | State Police |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Robert Ryan | Wiebka Marie Reimers |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Margaret A. Ryan - Wife | 833 St. George Court, Edgewood, Maryland 21040 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Angel Hill Cem. | 12/23/03 | Havre de Grace, MD |

21. Signature of Funeral Service Licensee: Stephen A Keefe

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE WITH COMPLICATIONS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CIRRHOSIS WITH COMPLICATIONS

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 No | 1 X Yes 2 No |

25. Was case referred to medical examiner? 1 X Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | O.C.M.E. | December 19, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41463

Rose, Sunda B patient known as SUNDA BEATRICE ROSE

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| SUNDA BEATRICE ROSE | December 19, 2003 | 8:05 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai hospital of Baltimore | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-28-5606 | 1 ☐ M 2 ☒ F | 71 Yrs. | | | JULY 6 1932 | MD. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11 WINDSONG COURT | 21208 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) 5+ | PROPRIETOR | MEN'S RETAIL CLOTHING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| MANUEL MILLER | HELEN HIMELFARB |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. FRANCINE ADLER/DAUGHTER | 104 MONTEROY ROAD ROCHESTER NY.14618 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | BALTIMORE HEBREW | 12/21/2003 | REISTERSTOWN,MD. |

21. Signature of Funeral Service Licensee ▶ Gary R

22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE,MD. 21208

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Chronic obstructive pulmonary disease
Due to (or as a consequence of):
c. Coronary artery disease
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive heart failure
Diabetes Mellitus
End stage Renal disease

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Aditi Gupta MD | RES-000 | December 19, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADITI GUPTA, MD, SINAI HOSPITAL OF BALTIMORE.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

24

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41464

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Elsie Smith
2. Date of Death: Month 12 Day 16 Year 2003
3. Time of Death: 0345 AM
4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-90-6478
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 43 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 26 1960
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1326 MARYLAND AVE APT 1
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 9th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UNEMPLOYED
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): GEORGE M SMITH
18. Mother's Name (First, Middle, Maiden Surname): LOUISE QUICKLEY

19a. Informant's Name/Relationship (Type, Print): Joy Smith/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1602 DRUID HILL AVE., BALTIMORE, MARYLAND 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT ZION CEMETERY
Date: 12-24-03
20c. Location - City or Town, State: LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee: Charles H Powell
22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Intracerebral hemorrage — 6 hours
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K. Gallagher, MD
29c. License number: P16546
29d. Date signed (Month, Day, Year): 12/16/03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Katherine Gallagher, MD 29 South Greene Street Baltimore, MD

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41465

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Joseph Richard Sagle | December 17, 2003 | 2158 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Harford Memorial Hospital | Havre de Grace | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-14-8275 | 1☐M 2☒F | 90 Yrs. | | | June 30, 1913 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Harford | Havre de Grace | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 309 Heather Way | 21078 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1943 to 1946 | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 years | | photo lab technician | federal government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Thomas Edgar Sagle | Charlotte Musgrave |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gertrude Jewell Sagle/wife | 309 Heather Way, Havre de Grace, Md. 21078 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | St. Paul's Cem. | 12/22/03 | Aberdeen, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Renal Failure | ~ 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Sepsis — Due to (or as a consequence of): | ~ 2-3 days |
| | c. Cardiomyopathy — Due to (or as a consequence of): | for years |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Seizures
Hypothermia
Hypertension

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Jennifer A. Knuth MD, FACP | MD D50040 | 12-18-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1308 Business Park Way #102, Edgewood MD 21040

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41466

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Francis Michael Saxon, Sr. | December 20, 2003 | 12:45 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Stella Maris | Timonium | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 220-03-0971 | 1 [X] M 2 [ ] F | 82 Yrs. | | | | | Oct. 15, 1921 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Perry Hall | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9214 Snyder Lane | 21128 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Engineer | Aerospace Defense |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Michael Saxon | Mary Tomko |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Patricia A. Robey (dghtr) | 12 Blue Bell Court, Port Deposit, MD 21904 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Sacred Heart of Mary | 12/23/03 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Brian Carmichael | Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. **END STAGE SARCOMA**

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) **HOSPICE**

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 [ ] Yes 2 [ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D43725 | 12/22/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

DECEMBER 20, 2003 12:45 p.m.
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

FRANCIS SAXON
Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41467

DECEMBER 21, 2003 4:40 a.m. Baltimore, Maryland 21215-0036

JOHN SYCHUK

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month Day Year) | 3. Time of Death |
|---|---|---|
| John Thomas Sychuk, Sr. | December 21, 2003 | 4:20 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Stella Maris | Timonium | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-03-2435 | 1☒ M 2☐ F | 86 Yrs. | | | Oct. 7, 1917 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9419 Perry Hall Blvd. | 21236 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th Grade | | Clerk | Steel Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Timothy Sychuk | Ksenin Chenny |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Emilie Sychuk (wife) | 9419 Perry Hall Blvd., Baltimore, MD 21236 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Gardens of Faith Cem. | 12/24/2003 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Brian A Weller | Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ALZHEIMER'S DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown | 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? 1☐ Yes 2☒ No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No |
|---|---|

| 25. Was case referred to medical examiner? 1☐ Yes 2☒ No | 26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D43725 | 12/22/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Rayne Stewart
03-08106
MAN

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend & Unpend Item #1,23a,27,28a-f per the G828 2/3/04 tas

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 11468

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| RAYNE' MARIE STUART | December 16, 2003 | 1028 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Harbor Hospital | Baltimore | BALTIMORE CITY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | Days | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 220-67-6335 | 1☐M 2☒F | Yrs. | | 25 | | | NOV. 21, 2003 | MARYLAND |

2853

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | GLEN BURNIE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7720 B.& A. BLVD., APT. A | 21060 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 0 | | NONE | N/A |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| EDWARD E. STUART | JANET WILDBERGER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| EDWARD E. STUART / FATHER | 7729 B. & A., BLVD., APT. A, GLEN BURNIE, MD 21060 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | GLEN HAVEN MEM. PARK | DECEMBER 22 2003 | GLEN BURNIE, MARYLAND |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sudden Unexplained Death in Infancy

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| 12/16/03 | unknown M | 1☐Yes 2☒No | Unknown |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 2208 Annapolis Rd. Baltimore, Md

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Patricia Aronica-Pollak MD | O.C.M.E. | December 17, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PATRICIA ARONICA-POLLAK 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

OK

Kenneth L. Steininger

UNK 03-392
03-8037
DAP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEM 23a,27&28a-f PER ME G827 1/07/04 JH

# Certificate of Death

Reg. No. 2003 41469

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Kenneth Lee Steininger | DECEMBER 14, 2003 | 12:20 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| COLLINS WHARF ROAD | EDEN | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-38-2385 | 1 X M 2 F | 62 Yrs. | | | 6-7-41 | Md. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Wicomico | Delmar | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8955 Star Road | 21875 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 Widowed 4 X Divorced | 1 X Yes 2 No 1959-1963 | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Salesman | Paper Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Paul E. Steininger | Jessie Sprague Steininger |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Katherine E. Marvel, Daughter | 8957 Star Rd. Delmar, Md. 21875 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Crematory of Delmarva | 12-16-03 | Delmar, De. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SMOKE AND SOOT INHALATION AND THERMAL BURNS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ✓ Yes 2 No | 1 ✓ Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| XX Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 XX Other (Specify) AT SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 Natural XX Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | 12/13/03 | 11:16 M | 1 Yes 2 XX No | driver of car ran off road into ditch Car caught on fire |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): ROADWAY

28f. Location (Street and Number or Rural Route Number, City or Town, State): COLLINS WHARF RD. WICOMICO, MD.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] for | OCME | DECEMBER 14, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. Kovell M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 29 2003 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41470

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| HILDA SEMONES | 12 | 21 | 03 | 11:21 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Johns Hopkins Bayview Medical Center | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 232-48-4490 | 1☐M 2☒F | 71 Yrs. | | | Oct. 9, 1932 | West Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Dundalk | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8544 Kavanagh Road | 21222 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 Years | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Dana Kirkpatrick | Phoeba Hess |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. James A. Semones (Husband) | 8544 Kavanagh Road Dundalk, Maryland 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Holly Hill Mem. Gdns. | 12/24/2003 | Middle River, Maryland |

21. Signature of Funeral Service Licensee: Duda-Ruck Funeral Home of Dundalk, Inc.

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | End stage Renal Disease | years |
| Due to (or as a consequence of): b. | End stage Liver Disease | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation
Pleural effusions
Hypertension

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Medical Doctor Housestaff | RES-000 | 12/21/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
4940 Eastern Avenue, Baltimore, Maryland 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41471

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Kenneth Preston Scheffenacker | 12 / 20 / 03 | 2:20 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Upper Chesapeake Medical Center | Bel Air | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-78-6783 | 1 [X] M 2 [ ] F | 46 Yrs. | | | Oct. 23, 1957 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Fallston | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3200 Glouchester Drive | 21047 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Investor | Real Estate |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jon Preston Scheffenacker | Carolann DeChiaro |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Carolann Gallagher / mother | 17 Spyglass Court; Timonium, MD 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) entombment | Dulaney Valley Mem Gardens | 12/23/03 | Timonium, MD |

21. Signature of Funeral Service Licensee: Michael Koch

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, MD 21204

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Colon Cancer | 6 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) ____ 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 [ ] Yes 2 [ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D45390

29d. Date signed (Month, Day, Year): December 21st, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MYO MIN (M.D.) 602 South Atwood Road #200, Bel Air, MD 21014

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Scheffenacker, Kenneth #395346 12/20/03 2:20p.m.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41472

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Truman Lester Smith | DECEMBER 18, 2003 | 06:52 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Saint Joseph Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 194-07-5464 | 1☒M 2☐F | 86 Yrs. | | | Feb. 9, 1917 | PA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Timonium | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1903 York Road | 21093 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Mechanical Designer | Engineering |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Erwin Smith | Elmeda Simon |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Virginia R. Smith/spouse | 1903 York Road Timonium, Maryland 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment | Dulaney Valley Mem. Grdn | 12/22/2003 | Timonium, Maryland |

| 21. Signature of Funeral Service Licensee | S.D. Coster | 22. Name and Address of Facility | Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 |
|---|---|---|---|

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SUDDEN CARDIAC DEATH | 2MINUTES |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. CONGESTIVE CARDIOMYOPATHY | 3 YEARS |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

BENIGN PROSTATIC HYPERTROPHY

OSTEOPOROSIS

| 23a. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) — Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) — 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Jogider P. Mehta M.D. | D 41410 | December 18th, 2003. |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGIDER P. MEHTA M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204-7582

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41473

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Betty Louise Smith | December 19, 2003 | 1:30 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 82 Midway Avenue | Laurel | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 229-32-1374 | 1☐M 2☒F | 74 Yrs. | | | Mar 24, 1929 | Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Howard | Laurel | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 82 Midway Avenue | 20723 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Roy Thomas Pugh | Bessie Chaplin |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Edward C. Smith, Sr. /spouse | 82 Midway Avenue. Laurel, Maryland 20723 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Ivy Hill Cemetery | Dec 23, 03 | Laurel, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Louise Donaldson M00160 | Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sudden death | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Severe tricuspid regurgitation | 2 years |
| | Due to (or as a consequence of): | |
| | c. Hypertension | 20 years |
| | Due to (or as a consequence of): | |
| | d. Congestive heart failure | 5 years |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M Carrico MD | Virginia 0101058343 | December 22, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margaret E. Carrico, M.D. Family Practice Kimbrough Army Community Hospital Ft. Meade, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41474

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| CATHERINE | SMITH | | DECEMBER | 18 | 2003 | 0755 P.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 232-44-8076 | 1☐ M 2☒ F | 80 Yrs. | | | | | JUNE 21 1923 | SCOTLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | SEVERN | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 790 JENNIE DRIVE | 21144 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grede completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | INSTRUCTOR | DANCE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| LIVINGSTONE IZATT | Unknown |

| 19a. Informent's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) |
|---|---|
| MR. STEVEN SMITH (SON) | 790 JENNIE DRIVE SEVERN MARYLAND 21144 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | MARYLAND VETERANS CEMETERY | 12/22/2003 | CROWNSVILLE MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ M01195 | SINGLETON FUNERAL HOME P.A. 1 SECOND AVENUE S.W. GLEN BURNIE MD. 21061 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE MYOCARDIAL INFARCTION | 1 HOUR |
| Due to (or as a consequence of): | b. GENERALIZED ARTERIOSCLEROSIS | 10 YEARS |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | |
| Due to (or as a consequence of): | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- DIABETES
- DEMENTIA

| 23b. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicaf Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M.D. | D-22609 | DECEMBER 19.2003 |

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)
RUBEN REIDER M.D. 7445 FURNACE BRANCH Rd Glen Burnie Md 21060

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Merylend Department of Health end Mental Hygiene.
**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the death certificete be executed within 24 hours after death.
**To the Funeral Director:** After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41475

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Josephine Anna Smith

2. Date of Death: Month December, Dey 19, Year 2003

3. Time of Death: 1453

4a Facility Name (If not institution, give street and number): Lorien-Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 216-18-6460

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): May 3, 1922

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1909 Emmorton Road

10f. Zip Code: 21015

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Francis Cicero

18. Mother's Name (First, Middle, Maiden Surname): Barbara Hoffinagle

19a. Informant's Name/Relationship (Type, Print): Mrs. Barbara J. Fiore/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 408 E. Broadway Bel Air, MD 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 12/22/03

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Mark T. [illegible]

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway Bel Air, MD 21014

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after daath with tha Maryland Department of Haalth and Mantal Hygiana. **Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Assisted Living

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law raquiras that tha daath cartificata be executed within 24 hours aftar daath. To the Funeral Director: Aftar this cartificata has been signed by tha attanding physician and completaly filled in by tha funaral diractor, paga 2 should be datached for usa as tha burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ [signature]

29c. License number: D0055034

29d. Date signed (Month, Day, Year): 12/20/2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. JACQUES CONWAY 520 Upper Chesapeake Dr. Bel Air, MD. 21014

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41476

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Andrew L. Smith

2. Dete of Deeth: Month December Day 14 Yeer 2003

3. Time of Death: 12:15P.m

4e Fecility Name *(If not institution, give street end number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Deeth: Anne Arundel

**Funeral Director**

5. Social Security Number: 217 09 4991

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthdey)*: 82 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 28, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Anne Arundel

10c. City, Town or Locetion: Linthicum

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 726 East Maple Road

10f. Zip Code: 21090

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Eduction *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Insurance Broker

16b. Kind of Business/Industry: Self employed

17. Father's Name *(First, Middle, Last)*: Richard T. Smith

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Frances Polzin

19a. Informant's Name/Relationship *(Type, Print)*: Antoinette Smith / wife

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 726 East Maple Road Linthicum, Maryland 21090

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Cross Cemetery

Date: 12/22/03

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jerome Gonce

22. Name and Address of Facility: George J. Gonce Funeral Home, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225

**Physician /Medical Examiner**

23a. Part1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: MD.

29c. License number: D43977

29d. Date signed *(Month, Day, Year)*: December 14 2003

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): Anyon One Time. 301 Hospital Drive Glen Burnie. MD 21061.

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 23 2003

32. Registrar's Signature

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

ANDREW SMITH

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41477

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| John William Talbott Jr | 12- 20- 03 | 6:33 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Franklin Square Hospital Center | Bosedale | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217 26 5621 | 1 X M 2 F | 73 Yrs. | | | September 22 1930 | Baltimore Co., MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore County | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7105 Willowdale Avenue | 21206 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 X Yes 2 No If Yes, Give Year or Dates: WW II | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | N/A | Mechanist | Bethlehem Steel Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John William Talbott Sr | Marjorie Edwards |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Agnes A Talbott (Wife) | 7105 Willowdale Avenue Baltimore, Maryland 21206 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Gardens of Faith Cem. | December 22 2003 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute MI

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CAD

Due to (or as a consequence of):
c. ESRD

Due to (or as a consequence of):
d. Diabetes Mellitus

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D55885 | 12/20/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Jack NO 9000 Franklin Square Drive Baltimore, Md. 21237

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Talbott, John

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41478

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Joan Susan Tracey | December 19 2003 | 11:50 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GREATER BALTIMORE MEDICAL CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-24-6138 | 1☐M 2☒F | 76 Yrs. | | | November 16, 1927 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Carroll | Eldersburg | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6820 Hickory Lane | 21784 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Register Nurse | Private Practice |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Roland Hoge | Edna Hartley |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John H. Tracy (Son) | 2500 Greenspring Valley Road Owings mills, MD 21117 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| ☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Lake View memorial PArk | Dec. 22,2003 | Sykesville, MD |

21. Signature of Funeral Service Licensee: Joseph J Kelbaugh (M00333)

22. Name and Address of Facility: LoringByers Funerl Directors,Inc. 8728 Liberty Rd., Randallstown, MD 21133-4784

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. T-Cell Lymphoma — One months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| M.D. | D53654 | Dec. 19, 03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
YAO YAO ZHU, 6565 N. Charles #203, Balto MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Tracey, Joan S.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41479

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary E. Taylor.

2. Date of Death Month Day Year: December 17, 2003

3. Time of Death: 3:00 P M

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 213-20-3590

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): Oct. 16, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6336 Cedar Lane #337

10f. Zip Code: 21044

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Booth

18. Mother's Name (First, Middle, Maiden Surname): Emma Unknown

19a. Informant's Name/Relationship (Type, Print): Ronald W. Kasemeyer (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8263 Woodward Street Savage, Maryland 20763

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn

Date: 12-22-2003

20c. Location - City or Town, State: Mariottsville, Maryland

21. Signature of Funeral Service Licensee: P. St Dorsey

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave Catonsville, Maryland 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — Approximate Interval: Sudden

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Coronary Artery disease.

Atherosclerotic Cardiovascular disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D22856

29d. Date signed (Month, Day, Year): December 17, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jerry I. Levine, MD 11055 Little Patuxent Pkwy, Columbia, Md 21044

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #24a,25,26 23e PER PHY G826 12/23/03 JR

# Certificate of Death

Reg. No. 2003 41480

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William Valliant
2. Date of Death (Month, Day, Year): December 17, 2003
3. Time of Death: 9:55 AM
4a. Facility Name (If not institution, give street and number): The Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 215-22-0127
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 27 1926
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 105 Caraway Road Apt 1B
10f. Zip Code: 21136
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): salesperson
16b. Kind of Business/Industry: bakery

17. Father's Name (First, Middle, Last): Stephen Clifton Valliant
18. Mother's Name (First, Middle, Maiden Surname): Helen Marie Wilson

19a. Informant's Name/Relationship (Type, Print): Diana Frizzell (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Glynn Garth, Reisterstown, Md 21136

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet.
Date: 12-29-03
20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funeral Service Licensee: Paige Haight Herbert
22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — Two day
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. End stage of Renal disease — Three years
Due to (or as a consequence of):
c. Hypertention
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Qinglin Gao, MD
29c. License number: D0059855
29d. Date signed (Month, Day, Year): December 17, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Qinglin Gao, MD 5601 Loch Raven Boulevard, Baltimore, MD 21239

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature:

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41481

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Rose Vassallo | December 21 2003 | 10:15A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Brooke Grove Retirement Center | Ashton | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 158-10-1578 | 1☐ M 2☒ F | 86 Yrs. | | | April 15,1917 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| N.J. | Gloucester | Franklin Twp. | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| P.O. Box E | 08328 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No *Specify:* | *Specify:* White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Co-Owner/Operator | Truck & Tractor Sales |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| Frank Cairone | Mary Grace DiMatteo |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ronald Vassallo (Son) | 38 Taylor Road Newfield, N.J. 08344 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify) | Sacred Heart Cemtery | 12-24-2003 | Vineland, N.J. |

21. Signature of Funeral Service Licensee: John Evans

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc, 1630 Edmondson Avenue Catonsville, MD 21228

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ASPIRATION PNEUMONIA | 48 HOURS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE CONGESTIVE HEART FAILURE

RENAL INSUFFICIENCY

SENILE DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Ted Howe | D33700 | DECEMBER 22, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TED E. HOWE 154 N. ARTIZAN ST. WILLIAMSPORT, MARYLAND 21795

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41482

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Concettina M. Vinci | December 19 2003 | 11:50P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Joseph Richey Hospice | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-56-1514 | 1☐ M 2☒ F | 97 Yrs. | | | Jan 31, 1906 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Catonsville | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1406 Harberson Road | 21228 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Peter Vinci | Concettina Brocato |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Concetta Vinci (Daughter) | 1406 Harberson Road Catonsville, MD 21228 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | New Cathedral Cemetery | 12-23-03 | Baltimore, Maryland |

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARRHYTHMIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
END STAGE DEMENTIA.
CORONARY ARTERY DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD (PHYSICIAN) | D00 55532 | 12/20/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
6565 N. CHARLES ST, # 310, BALTIMORE, MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Concettina Vinci 12/19/03 1150 PM

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41483

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Isiah Wheeler

2. Date of Death Month Day Year: December 21 2003

3. Time of Death: 8:39 PM

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 223-24-5799

6. Sex: 1 M 2 F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/9/16

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 Yes 2 No

10e. Street and Number: 2828 Pelham Avenue

10f. Zip Code: 21213

10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Industrial

17. Father's Name (First, Middle, Last): William Pollaid

18. Mother's Name (First, Middle, Maiden Surname): Louise Wheeler

19a. Informant's Name/Relationship (Type, Print): Ronald Wheeler (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3313 Croydon Road Balto. MD 21217

20a. Method of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park Date: 12/29/03

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Vaughn Greene

22. Name and Address of Facility: Vaughn C. Greene Funeral Services 4905 York Road, Balto MD 21212

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. myocardial Infarction — Approximate Interval Between Onset and Death: 2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Diabetes mellitus — Due to (or as a consequence of): — >10 years

c. Coronary Artery Disease — Due to (or as a consequence of): — >10 years

d. — Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jrodel Hoheimann M.D.

29c. License number: AT 24388946 DO

29d. Date signed (Month, Day, Year): December 21, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J Todd Hoffman

Univ. of Maryland Hospital 201 E University Pkwy. Baltimore, MD 21218

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41484

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| MABEL | SERISA | WHITE | DECEMBER | 20 | 2003 | 6:15 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| MARINER HEALTH OF NORTH ARUNDEL | GLEN BURNIE | AACO. |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-22-2220 | 1☐ M 2☒ F | 91 Yrs. | | | 12-28-1911 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | ANNE ARUNDEL | SEVERNA PARK | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 861 BALTIMORE ANNAPOLIS BLVD | 21146 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | CUSTODIAN | A.A.COM. COLLEGE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| NATHAN EDWARDS | KATIE WATTS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MYRTLE GOODWIN/NIECE | 7909 FREETOWN RD. GLEN BURNIE, MD 21060 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | CEDAR HILL CEM | 12/26/03 | BALTIMORE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ James A. Morton | JAMES A. MORTON & SONS F.F., INC 1701 LAURENS ST., BALTO., MD 21217 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Cardiorespiratory Accident

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b. Renal failure

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D46816 | 12/23/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. ANIL CHOPRA, Mariner Health, Glen Burnie, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41485

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Margaret | Wheeler | December 18, 2003 | 10:30 pm M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Heritage Nursing Center | Dundalk | Baltimore County |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-05-8356 | 1☐ M 2☒ F | 85 Yrs. | | | August 12, 1918 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2825 Lodge Farm Road | 21219 | U. S. A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th Grade | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Schmidt | Margaret Unknown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Donald M. Buddenbohn (Nephew) | 4455 Douglas Ave., Apt 8C, Riverdale, N. Y. 10471 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Most Holy Redeemer Cem. | 12/20/03 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Brian A. Miller | Schimunek Funeral Home, Inc. 3331 Brehms Lane Baltimore, Maryland 21213 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ALZHEIMERS DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CAD — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d. — Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ A. Chatterjee | D23V30 | 12-19-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ashok Chattergee, M.D., 3927 Annapolis Rd., Baltimore, Maryland 21227

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

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ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **Amend Item #30 per dvr** G826 12/23/03 las *Certificate of Death* Reg. No. 2003 41486

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MARY E. WAGNER
2. Date of Death Month / Day / Year: DEC. 23 2003
3. Time of Death: 3:53 A M
4a. Facility Name *(If not institution, give street and number)*: MORNINGSIDE HOUSE
4b. City, Town, or Location of Death: HANOVER
4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 215-03-1438
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: JUNE 28, 1915
9. Birthplece *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 119 GARRETT ROAD
10f. Zip Code: 21060
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER
16b. Kind of Business/Industry: MANUFACTURING

17. Father's Name *(First, Middle, Last)*: ALBERT SELTZER
18. Mother's Name *(First, Middle, Maiden Sumame)*: MARY HODES

19a. Informant's Name/Relationship *(Type, Print)*: PHYLISS SEWARD/DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 119 GARRETT RD. GLEN BURNIE, MD 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GLEN HAVEN MEM. PK.
Date: DECEMBER 27 2003
20c. Location - City or Town, Stete: GLEN BURNIE, MD

21. Signature of Funeral Service Licensee: Bill L. Ebaugh
22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Myocardial Infarction
Due to (or as a consequence of):
b. Congestive Heart Failure .
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown
23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cardiac Pacemaker

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *Check only one*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: one Chopra
29c. License number: D 46819
29d. Date signed *(Month, Dey, Year)*: 12/23/2003
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anil Chopra 301 Locust Thorn Ct. Millersville, MD 21108

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 23 2003
32. Registrar's Signature: Ann L. Gorman

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41487

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JAMES WILLIAM WRIGHT | DEC. 21 2003 | 10;13 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| CROFTON CONVALESCENT CENTER | CROFTON | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 234-01-6886 | 1 [X] M 2 [ ] F | 84 Yrs. | | | SEPT. 15, 1919 | WEST VIRGINIA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | GLEN BURNIE | 1 [ ] Yes 2 [X] No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 606 BAYLOR ROAD | 21061 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes XX [X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | IRON WORKER | MANUFACTURING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JAMES HENRY WRIGHT | BLANCHE EDNA BUTLER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| VICTORIA SCHELHOUSE/DAUGHTER | 2608 CHAPEL LAKE DR. SUITE 207 GAMBRILLS, MD 21054 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | GLEN HAVEN MEM. PK. | DEC. 27, 2003 | GLEN BURNIE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident — 10days

Due to (or as a consequence of):
b. Aphasia — 10d

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Dysphagia — 10d

Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes XX [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) — 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D35848 | 12/23/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Howard K Schultz 1438 Defense Hwy Gambrills MD 21054

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41488

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Helen Wilmer

2. Date of Death: Month: December Day: 21 Year: 2003

3. Time of Death: 3:55 PM

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 217-34-4354

6. Sex: 1 ☐ M ☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 14, 1913

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ 1 Yes 2 ☐ No

10e. Street and Number: 1013 Union Avenue

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: In Own Home

17. Father's Name (First, Middle, Last): Adolph Kolakowski

18. Mother's Name (First, Middle, Maiden Surname): Josephine Popiolek

19a. Informant's Name/Relationship (Type, Print): Geri Rittermann (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4210 Elsa Terrace Baltimore, Maryland 21211

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Pk

Date: 12/26/03

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licens: Jerry A. Carpenter

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Pulmonary Disease — 20 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Todd Haberman M.D.

29c. License number: MD 243896 DO

29d. Date signed (Month, Day, Year): December 21, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Todd Haberman Union Memorial Hospital 201 E. University Pkwy Baltimore, MD 21218

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41489

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Walter | O. | Watson | December 18, 2003 | 16:05 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Calvert Memorial Hospital | Prince Frederick | Calvert |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 191-18-7536 | XX 1 M 2 F | 81 Yrs. | | | July 21, 1922 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Calvert | Lusby | 1 Yes 2 XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 50 Appeal Lane Apt. 215 | 20657 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 XX Married 3 Widowed 4 Divorced | XX Yes 2 No If Yes, Give Year or Dates: WW II | 1 Yes 2 XX No Specify: | Specify White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Steel Worker | Steel |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Walter Watson | Mary Johns |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Joan C. Watson (wife) | 50 Appeal Lane Apt. 215 Lusby Maryland 20657 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Hilltop Service Corp. | 12/22/2003 | Towson, Maryland |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Adenocarcinoma of lung | months |
| Due to (or as a consequence of): b. | Atrial fibrillation | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. | status - post cerebrovascular accident | > 30 yrs. ago |
| Due to (or as a consequence of): d. | Hypertension | many years |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Prostate cancer

Asbestos exposure

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ✓ Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 ✓ No | 1 Yes 2 ✓ No |

25. Was case referred to medical examiner? 1 Yes 2 ✓ No

26. Place of Death (Check only one): Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ✓ Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ✓ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature], MD | D 60390 | 12/19/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ADEEB JABER 100 Hospital Rd., Prince Frederick, MD 20678

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | [signature] |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41490

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: James Gibbons Wooden

2. Date of Death (Month, Day, Year): December 21, 2003

3. Time of Death: 11:40 PM

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 216-07-0617

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 01/07/1919

9. Birthplace *(State or Foreign Country)*: MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 487 Center Street

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Various Deliveries

17. Father's Neme *(First, Middle, Last)*: James Joseph Wooden

18. Mother's Name *(First, Middle, Maiden Surname)*: Helena Christ

19a. Informant's Name/Relationship *(Type, Print)*: James Wooden/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 487 Center St., Pasadena, MD 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD Veterans Cemetery

Date: 12/29/03

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: G.J. Gonce Funeral Home, PA
169 Riviera Dr., Pasadena, MD 21122

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Due to (or as a consequence of): b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD

29c. License number: D48806

29d. Date signed *(Month, Day, Year)*: December 22, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI BONITEY, 301 Hospital Dr., Glen Burnie, MD

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

James Wooden

8+1

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 23 2003

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2003 41491

WHITEHURST, HARRIET

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Harriett | Cooley | Whitehurst | December 18, 2003 | 3:40pm M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Lorien Nursing and Rehabilitation | Bel Air | Harford |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-32-6933 | 1☐M 2☒F | 70 Yrs. | | | July 27, 1933 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Bel Air | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 922 James Street | 21014 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Gilbert Cooley | Elsie K.C. Crowell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| James R. Whitehurst- Husband | 922 James Street, Bel Air, Maryland 21014 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Hilltop Service Corp. | 12/22/03 | Towson, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CEREBROVASCULAR ACCIDENT | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER, HYPERTENSION, DIABETES MELLITUS, CHRONIC RENAL FAILURE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D45344 | 12/19/2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SURESH DHANJANI MD, 622 S. CANON AVE, HAVRE DE GRACE, MD 21078

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 ▶ | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41492

**Physician /Medical Examiner** | **Funeral Director**

1. Decedent's Name (First, Middle, Last): Thelma Juanita Gifford Wade
2. Date of Death (Month, Day, Year): December 22, 2003
3. Time of Death: 5:30 AM
4e. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel
5. Social Security Number: 175-09-2216
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.18,1911
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Gambrills
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 2336 Maytime Drive
10f. Zip Code: 21054
10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12th; College (1-4or 5+):
16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Paper Company

17. Father's Neme (First, Middle, Last): Clare Montgomery Gifford
18. Mother's Name (First, Middle, Maiden Sumame): Ethol Mildred Hull

19a. Informant's Name/Reletionship (Type, Print): Carolyn H. Spohr/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2336 Maytime Drive Gambrills, Maryland 21054

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): West Arundel Crematory
Date: 12/23/03
20c. Location - City or Town, State: Odenton, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas M00957
22. Name and Address of Facility: Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113

**Physician Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Coronary Artery Disease | 10yrs |
| Due to (or as a consequence of): b. | Hypertension | 10yr |
| Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Congestive Heart Failure | 10yr. |
| d. | Esophageal Stricture | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ronald C Sroka MD
29c. License number: D0018480
29d. Date signed (Month, Day, Year): 12/22/03

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): RONALD C. SROKA, M.D. 1684 VILLAGE GREEN, CROFTON MD 21114

**State Registrar**

31. Date filed (Month, Day, Year): DEC 23 2003
32. Registrar's Signature

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or item 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours efter death.
**To the Funeral Director:** After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41493

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Rosalee YOUNG | | | 12 / 19 / 2003 | 4 11 P M |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | | |
| Bon Secours Hospital | Baltimore | N/A | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-14-6878 | 1 ☐ M 2 ☒ F | 74 Yrs. | | | JUNE 7 1929 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE | 1 ☒ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2829 EDGECOMB CIR N. | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11th grade | | HOUSEWIFE | DOMESTIC |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CURTIS MILLER | VIOLE JETT |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Vandessa Young/Daughter | 2829 Edgecomb Cir. N., Balto., Maryland 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | METRO CREMATORY | 12-27-03 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Charles L. Powell | WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Respiratory Failure and Shock | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Terminal Respiratory Aspiration | 3hours |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Parkinsons Disease

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 ☐ Yes 2 ☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ H. Neal Powell MD | D27163 | 12/22/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bon Secours Hospital of Baltimore, West Baltimore St.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 23 2003 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2
5

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2003 41494

ZHANG, LAN

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: LAN JIN ZHANG
2. Date of Death (Month / Day / Year): December 11 2003
3. Time of Death: 8:15 pm

4a Facility Name *(If not institution, give street and number)*: Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 215-35-6065
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 18, 1929
9. Birthplace *(State or Foreign Country)*: China

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3814 Mayberry Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: China

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 0 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Homemaker

17. Father's Name *(First, Middle, Last)*: Unobtainable
18. Mother's Name *(First, Middle, Maiden Surname)*: Unobtainable

19a. Informant's Name/Relationship *(Type, Print)*: Dun S. Cheng/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3814 Mayberry Avenue, Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery
20c. Location - City or Town, State | Date: 12/21/03 Brentwood, Maryland

21. Signature of Funeral Service Licensee: Nancy A. Pecantin
22. Name and Address of Facility: FORT LINCOLN FUNERAL HOME 3401 Bladensburg Road, Brentwood, Maryland 20722

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Carcinoma of the Breast + lung
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☑ Other *(Specify)* Hospice

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marvin Feldman MD
29c. License number: D07930
29d. Date signed *(Month, Day, Year)*: December 15, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marvin J. Feldman 301 St PAUL PL Baltimore MD. 21202

**State Registrar**

31. Date filed *(Month, Day, Year)*: DEC 23 2003
32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41495

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Tyrone Brutus Adams
2. Date of Death (Month, Day, Year): December 21 2003
3. Time of Death: 6:30 PM
4a. Facility Name (If not institution, give street and number): Baltimore VA Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 278-46-0927
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 55 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPTEMBER 4, 1948
9. Birthplace (State or Foreign Country): W. VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2857 Hollins Ferry Road
10f. Zip Code: 21230
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12TH GRADE
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COOK
16b. Kind of Business/Industry: HOTEL

17. Father's Neme (First, Middle, Last): JAMES MILLER
18. Mother's Name (First, Middle, Maiden Surname): EDNA ADAMS

19a. Informant's Name/Relationship (Type, Print): GLENDORA WILLIAMS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2857 HOLLINS FERRY RD, BALTIMORE, MD 21230

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 12-24-03
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Dietrich N. Williams
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD 21217

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Stroke — one month

Due to (or as a consequence of):
b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hypertension

Due to (or as a consequence of):
d. Hyperlipidemia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mollie M. Davis
29c. License number: P16729
29d. Date signed (Month, Dey, Yeer): December 21, 2003

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): 20 South Greene St. University of Maryland Medical Center Baltimore MD 21201

**State Registrar**

31. Dete filed (Month, Day, Year): DEC 24 2003
32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41496

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| LIZZIE | C. | ALSTON | DEC. 21, 2003 | 6:30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| KENNISAW NURSING HOME | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-24-0833 | 1☐ M 2☒ F | 94 Yrs. | | | MAY 11, 1909 | SOUTH CAROLINA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE CITY | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2601 ROSALYN AVENUE | 21216 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10TH GRADE | | PRACTICAL NURSE | PRIVATE HOMES |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| UNKNOWN | UNKNOWN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| LILLIE MELTON (COUSIN) | 3802 MOHAWK AVE. BALTO. MD. 21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | MD. NATIONAL CEMETERY | 12-24-03 | LAUREL, MARYLAND |

21. Signature of Funeral Service Licensee: Patrick N. Williams

22. Name and Address of Facility: BROWN JR. FUNERAL HOME, 2140 N. FULTON AVE, BALTO. MD. 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ALZHEIMER'S Dementia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Osteoporosis
insulin dependent diabetes mellitus

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D18327 | 12/23/03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Moges Gebremariam. 4660 Wilkens Ave # 203, Balto Md 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 24 2003 | |

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41497

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Philip Bernard Amrhein, Sr.

2. Date of Death (Month, Day, Year): December 20 2003

3. Time of Death: 2:20P M

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-30-5949

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 9, 1934

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 959 Kayden Lane

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1955-1963

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): John Bernard Amrhein

18. Mother's Name (First, Middle, Maiden Surname): Rena Rossi

19a. Informant's Name/Relationship (Type, Print): Linda Amrhein (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 959 Kayden Lane, Baltimore, Maryland 21221

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart Of Jesus

Date: Dec. 23, 2003

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic transitional Cancer — 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypercholesterolemia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶

29c. License number: D54736

29d. Date signed (Month, Day, Year): 12-20-2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Kamlon Auyeung, 9000 Franklin Square Drive, Baltimore Md 21237

**State Registrar**

31. Date filed (Month, Day, Year): DEC 24 2003

32. Registrar's Signature ▶

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Amrhein Phillip

74

Joseph David Antkowiak Jr
03-08230
MAN

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar UNPEND ITEM 23a,27&28a-f PER ME G827 1/06/04 JH

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2003 41498

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Joseph David Antkowiak, Jr. | December 22, 2003 | 0220 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 952 Middlesex Road | Essex | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-27-8256 | 1☒M 2☐F | 18 Yrs. | | | April 1,1985 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Essex | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 952 Middlesex Road | 21221 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Laborer | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph David Antkowiak, Sr. | Kathleen L. Reinhard |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Kathleen Antkowiak (Mother) | 952 Middlesex Road, Baltimore, Maryland 21221 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gardens of Faith | Dec.26,2003 | Baltimore, Maryland |

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. NARCOTIC INTOXICATION | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? ☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) At scene

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day Year) found 12/22/03

28b. Time of Injury found 2:10a M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND IN RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State): 952 MIDDLESEX ROAD BALTIMORE,MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Theodore M. Kingsmore | O.C.M.E. | December 22, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 24 2003 | G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Funeral Director**

Preston Anderson

03-8134

MAN

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2003 41499

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Preston Anderson | December 18, 2003 | 0725 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2708 Sethlow Road | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-50-4653 | 1 ☑ M 2 ☐ F | 58 Yrs. | | | April 12, 1945 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1 ☑ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2708 Sethlow Road | 21225 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☑ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Truck Driver | Oil |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Anderson | Juanita Anderson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Carla Manrigo / daughter | 734 Roundview Road Baltimore MD 21225 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Mt. Zion Cem. | 12/27/03 | Lansdowne MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | Harry P. Close Funeral Service P.A. 309 Tessier St. Baltimore MD 21201 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Atherosclerotic Cardiovascular Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No | 24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No |
|---|---|

| 25. Was case referred to medical examiner? XX Yes 2 ☐ No | 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) At scene |
|---|---|

| 27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)

1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | O.C.M.E | December 18, 2003 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| DEC 24 2003 | ▶ |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2003 41500

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JESSIE BEVANS
2. Date of Death (Month, Day, Year): DECEMBER 19 2003
3. Time of Death: 1:00 A M
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE.

**Funeral Director**

5. Social Security Number: 238-40-6190
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 80 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): NOV. 23, 1923
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: PIKESVILLE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 817 JUDY LANE
10f. Zip Code: 21208
10g. Citizen of What Country?: USA.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LAUNDRY WORKER
16b. Kind of Business/Industry: LAUNDRY

17. Father's Name (First, Middle, Last): M. T. NEVILLE
18. Mother's Name (First, Middle, Maiden Surname): MARY HARRIS

19a. Informant's Name/Relationship (Type, Print): PERRY HAWKINS (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 817 JUDY LANE, PIKESVILLE, MD 21208

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK Date: 12-24-03
20c. Location - City or Town, State: WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee: Patrick N. Williams
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2190 N. FULTON AVE., BALTO, MD. 21217

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. PULMONARY EMBOLISM.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery (Month, Day, Year)

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA.
SEPSIS.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: PHYSICIAN.
29c. License number: D 42723.
29d. Date signed (Month, Day, Year): DECEMBER 19 2003.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AVVERAHALLI HARISH. NORTHWEST HOSPITAL CENTER. 5401 OLD COURT ROAD MD 21133.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

**State Registrar**

31. Date filed (Month, Day, Year): DEC 24 2003
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL